STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cynthia Henson,
Petitioner,

vs.

Chicago Transit Authority,
Respondent.

14IWCC0221

NO: 11 WC 10117

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 21, 2013 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 27 2014
KWL/vf
O-3/17/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0221

WALTON-FAIR, JAYNE
Employee/Petitioner

Case# 12WC039249

PREMIUM RETAIL SERVICES
Employer/Respondent

On 7/1/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1315 DWORKIN AND MACIARIELLO
CHRISTINE VARGHESE
134 N LASALLE ST SUITE 1515
CHICAGO, IL 60602

0532 HOLECEK & ASSOCIATES
LINDSAY RENIER
161 N CLARK ST SUITE 800
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

14IWCC0221

Jayne Fair-Walton
Employee/Petitioner

v.

Premium Retail Services
Employer/Respondent

Case # 12 WC 39249

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly C. Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **May 31, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☒ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Credibility**

FINDINGS

On **9/21/12**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did not* sustain an accident that arose out of and in the course of employment. In light of this finding, the Arbitrator views the remaining disputed issues as moot.

In the year preceding the injury, Petitioner earned $-- ; the average weekly wage was **$785.11**.

On the date of accident, Petitioner was **50** years of age, ***single*** with **0** dependent children.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER:

THE ARBITRATOR FINDS THAT PETITIONER WAS NOT CREDIBLE AND FAILED TO PROVE SHE SUSTAINED ACCIDENTAL INJURIES ON SEPTEMBER 21, 2012 ARISING OUT OF AND IN THE COURSE OF HER EMPLOYMENT. THE ARBITRATOR VIEWS THE REMAINING DISPUTED ISSUES AS MOOT

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Molly C Mosa
Signature of Arbitrator

6/28/13
Date

JUL -1 2013

Jayne Fair-Walton v. Premium Retail Services
12 WC 39249

Arbitrator's Findings of Fact

Petitioner claims a lifting-related work injury of September 21, 2012. Petitioner testified she worked as a sales assistant for Respondent as of that date. Her job required her to visit various stores such as Wal-Mart to train the employees of those stores how to use Respondent's products. T. 14-15. During the store visits, Petitioner would also unload training-related supplies. T. 15.

Petitioner testified she felt "fine" on the morning of September 21, 2012. T. 15. She went to the photo lab inside the WalMart store in Orland Park, Illinois that day in order to conduct "canvas wood" training (T. 32) and unload "HP supplies." T. 16, 29. Petitioner testified her injury occurred at around 1:00 or 2:00 PM, when she lifted an unexpectedly heavy box during the unloading process. T. 29-30. She described the injury as follows:

> "I actually was in the process of loading off some of the supplies off the cart and didn't realize the box was as heavy as it was and I kind of hollered because I didn't realize it was heavy and I went down with it. I hollered because I felt something weird pull on the left side – 'oh, my God, it's heavy,' and after that, I just kind of looked to say, what is it? We kind of opened up the box to check it out to see what was in it. That's when I realized it was a desk laminator inside that box."

T. 17, 33. Petitioner testified she was unloading the supplies by herself before the accident. T. 32-33. A WalMart associate was nearby when she performed the unloading, as was a male "stocker." These two individuals were within about six or seven feet of Petitioner when the injury occurred. T. 31. Some customers were also in the area. T. 33.

Petitioner testified that, after she lifted the box and "hollered out," a male employee of Respondent walked up to her. Petitioner testified she told this employee the box was "too heavy." The employee, who is named Shawn Wheeler, then attempted to lift the box. T. 34-35. Petitioner testified she has known Wheeler "through [the] years." She and Wheeler worked on a Respondent project together. They also worked together on a project for another employer. T. 35.

Petitioner testified the male stocker, a WalMart employee, came over to help following her accident. Petitioner testified she does not know the stocker's name. T. 35.

Petitioner testified she felt tingling in her left side, from her shoulder to her elbow, after she picked up the box. T. 17. A few minutes later, she pulled her jacket sleeve down in order to

look at her arm and noticed the arm was "kind of puffy." T. 21. Petitioner denied having any left shoulder problems prior to lifting the box. T. 17-18. After the accident, Petitioner started packing up her things and "ended up being able to leave." T. 21.

Petitioner testified she notified her regional manager, Troy Harnett, of her injury via telephone the evening of September 21, 2012. She left Harnett a voice mail message. The next morning, she sent Harnett a follow-up E-mail. She identified a document in subpoenaed documents marked as PX 1 as the E-mail she sent on September 22, 2012. T. 19. In the E-mail, she "re-capped" her workday, per Respondent's rules, and stated: "Supplie [sic] box with canvas materials are very heavy to carry or pull out onto floor. I have already had a hard time with it, I think I pulled a muscle trying to carry out the supplies." T. 20-21. PX 1. Several subsequent E-mails sent by Petitioner contain no mention of an injury. On October 10, 2012, Petitioner sent an E-mail to Tina Palermo and Harnett in which she discussed work-related issues and stated: "I pulled a muscle on my left side and I have some swelling. This is the second time this has happen [sic] after I pulled the hp supplies out . . . So I have given up on pulling supplies out at the store." [Respondent raised hearsay and other objections to PX 1 at the hearing. The Arbitrator overruled the hearsay objection as to the E-mails Petitioner authored and sent. The Arbitrator reserved ruling on the other objections. The Arbitrator overrules Respondent's various objections as to the Petitioner-authored E-mails that are in PX 1. The Arbitrator rejects and gives no consideration to the remaining E-mails in PX 1.]

Petitioner testified she last worked for Respondent on October 12, 2012. She left Respondent on that date because she felt "forced to resign." As of that time period, Respondent was "coercing" her into going out of town. She also was "questioning why no one [had] spoken with [her] about [her] injury." T. 28-29.

Petitioner testified she first sought treatment for her injury from "Dr. Goldstein" at "Advanced Physician" on October 22, 2012. T. 22. Records in PX 2 reflect that Petitioner saw Dr. Goldvekht at Advanced Physical Medicine on October 22, 2012. The doctor's history reflects that Petitioner was training staff and pulling supplies at a Wal-Mart store on September 21, 2012 when she "pulled her left shoulder due to the heavy load." Petitioner testified she explained and physically demonstrated the mechanism of injury to the doctor. T. 22. The doctor's history also reflects that Petitioner notified her regional manager of the injury but continued to work. Petitioner complained of pain radiating from her neck to her shoulder and down the left arm. Petitioner also complained of pain in her right mid-back.

On examination, Dr. Goldvekht noted a reduced range of cervical and thoracic spine motion, with spasms at end range. He also noted a markedly decreased range of left shoulder motion and multiple trigger points. He diagnosed sprains/strains of the cervical spine, thoracic spine and left shoulder. He took Petitioner off work through November 26, 2012. He prescribed Flexeril and a course of physical therapy. PX 2.

Petitioner underwent an initial physical therapy evaluation at Advanced Physical Medicine on October 24, 2012. The evaluating therapist noted that Petitioner was injured

while pulling supplies at work on September 4, 2012. PX 2. Petitioner attended therapy on a regular basis thereafter.

Petitioner returned to Dr. Goldvekht on November 19, 2012 and reported no improvement. She rated her pain level at 7/10. Dr. Goldvekht diagnosed "persistent left shoulder pain secondary to rotator cuff sprain and tendonitis." He injected Petitioner's left shoulder joint with Kenalog and Lidocaine. T. 25. He instructed Petitioner to continue taking Flexeril and attending therapy. He directed Petitioner to stay off work through December 17, 2012. PX 2.

On February 4, 2013, Petitioner returned to Dr. Goldvekht and reported improvement. She indicated she was no longer experiencing radiating pain. She complained of left shoulder aching with repetitive reaching and overhead activity. Dr. Goldvekht prescribed a three-week course of work conditioning. He kept Petitioner off work and prescribed Flexeril, Zatac and Mobic, to be taken as needed. PX 2.

Petitioner underwent work conditioning at Advanced Physical Medicine Centers on February 11 and 18, 2013. PX 2. T. 25-26.

On February 25, 2013, Dr. Goldvekht found Petitioner to have reached maximum medical improvement. He noted Petitioner was still experiencing intermittent left shoulder stiffness with repetitive activities. He released Petitioner to full duty and told her she could continue taking the previously prescribed medication on a PRN basis. PX 2.

Petitioner testified that, when she last saw Dr. Goldvekht, she told him she was feeling much better and no longer experiencing much swelling. T. 27.

Petitioner testified she received no workers' compensation benefits during the time that Dr. Goldvekht had her off work. T. 27-28.

Petitioner testified she still experiences a little tingling and swelling in her shoulder area from time to time. He injury has "very little" effect on her daily activities. If she uses her arm a lot to move things around, the arm starts feeling irritated. T. 28.

Petitioner testified her pain did not go away between the accident and her first visit to Dr. Goldvekht. T. 37.

Under cross-examination, Petitioner reiterated she resigned on October 12, 2012 and first saw Dr. Goldvekht on October 22, 2012. T. 37. Petitioner then clarified that she saw her personal physician, Dr. Bhan, before she saw Dr. Goldvekht. She told Dr. Bhan about the accident and her shoulder. T. 38-39. Dr. Bhan told her she could not treat the shoulder. Dr. Bhan told her she "needed to see a work comp doctor." T. 38.

Petitioner testified she asked her manager, Troy Harnett, for medical treatment due to her injury. T. 39.

Petitioner testified that Shawn Wheeler was in the Wal-Mart when her accident occurred but that Wheeler was not working with her that day. T. 39. Petitioner reiterated she knows Wheeler because they worked together for CLA and for Respondent. Petitioner denied seeing Wheeler socially. Since she was his manager, however, she sometimes had to drop off supplies to him. T. 40. Over her attorney's relevancy objection, Petitioner admitted being convicted of felony arson. She testified she was "falsely accused" of this crime. She "will be returning back to court for that." T. 42. She appealed her conviction to the Appellate Court. The Appellate Court upheld the conviction. She has not yet filed an appeal to the Supreme Court but "the other attorney who is working that case will be" filing an appeal. Petitioner testified that the person who was actually accountable for the arson was Shawn Wheeler. T. 42-43.

On redirect, Petitioner testified she worked for Respondent during two different time periods totaling about five years. The second period started in 2010. T. 43. She saw Dr. Bhan in late September 2012, after the accident. T. 43. When she first worked for Respondent, she worked "in the assistant sales side for about three years." T. 44. She was never written up at work during the periods she worked for Respondent. T. 44. Respondent asked her to move from the assistant sales side to the HP side, where her salary was higher. She has recruited employees for Respondent. She recommended several individuals, including Shawn Wheeler, to Respondent. T. 46. She was convicted of felony arson in about 2007, at which point she was employed by Respondent. T. 47. At that time, she had a different manager. This manager knew she had been falsely accused and had hired an attorney to "get this straightened out." T. 47-48. After she left Respondent, she worked for CLA before being re-hired by Respondent. Respondent took her back after the conviction. T. 47. On October 10, 2012, she received an E-mail from Michele Gohlke. T. 47-48. She identified this E-mail in the group of documents marked as PX 1. T. 48-49. Michele Gohlke is an account manager at Respondent. T. 50-51. She communicated with Gohlke concerning issues relating to "OnStar." T. 52. Petitioner testified she believed things were going well for her at work even after the injury. T. 53.

Petitioner called Lauren Paul to testify. Paul testified she knows Petitioner because Petitioner used to be the "HP rep" at the Wal-Mart store where Paul works. T. 56. After Paul acknowledged discussing the facts of the claim with Respondent's counsel via telephone two days before the hearing and meeting with Respondent's counsel just prior to the hearing, the Arbitrator allowed Petitioner's counsel to treat Paul as an adverse witness. T. 57-62. Paul also testified she gave a statement to a male representative of Travelers Insurance about six months prior to the hearing. T. 58, 61.

Paul testified she recalls the incident involving Petitioner but does not recall the date on which this incident occurred. Respondent's counsel informed her of this date. T. 59. Paul testified she was working in the photo department at WalMart on the date of the incident. She observed Petitioner lifting boxes and pulling supplies out on that date. She recalled Petitioner

saying that the boxes were heavy. T. 63. Petitioner called for assistance with the boxes. T. 64-65. A male individual came over to Petitioner and assisted her. Paul testified this individual had accompanied Petitioner to WalMart on a few previous occasions. The Individual was wearing a blue shirt bearing an HP logo. T. 63-64.

In response to questions posed by Respondent's counsel, Paul testified she was appearing pursuant to subpoena. T. 79. Paul testified that, when she conversed with Respondent's counsel two days before the hearing, Respondent's counsel "made sure" she was planning to appear at the hearing and went over her testimony. Respondent's counsel did not tell her what she was supposed to say, testimony-wise. T. 65-66. Paul testified she has worked at the WalMart in Orland Hills for almost nine years. She works in the photo lab as a "photo web specialist." T. 67. She knows Petitioner. Petitioner came to the photo lab on the day of the incident to show her new products. Petitioner typically comes to the store twice a year. T. 68. Paul testified she finds the visits of HP representatives memorable because those visits are infrequent. T. 68. On the day in question, Petitioner was in the store for an hour or two. T. 76. Petitioner showed her a video about a new product. Petitioner was accompanied by a male individual. This individual had accompanied Petitioner to the store on a few prior occasions. T. 69. Respondent's counsel then showed Paul a driver's license. Paul identified the person shown on the license as the male individual who accompanied Petitioner. T. 70. On those occasions when this individual accompanied Petitioner to the WalMart, he lifted "stuff" and worked with software on the HP machines. T. 71. Paul testified that, on the day in question, she was present during the entire time that Petitioner and the male individual were in the photo lab. Petitioner was within six feet of her. T. 71. Petitioner was removing boxes from a pallet. There were "lots of boxes" on the pallet. The male individual was "over by the kiosks" working on software. T. 72. Petitioner cautioned Paul against lifting a particular box. Petitioner asked the male individual to come over and lift that box. T. 72-73. Paul testified Petitioner did not wince, say "ouch" or otherwise do anything indicating she had hurt herself. T. 73. Petitioner did not tell Paul she had injured herself. T. 74. Paul testified she saw Petitioner leave the store. Petitioner was carrying her HP bag. Petitioner was not holding the bag gingerly or rubbing her arm or shoulder. T. 75. More than six months later, Petitioner called Paul and told her she was on a leave because she had hurt herself at WalMart. Paul found this surprising. She "didn't even know [Petitioner] got injured." T. 78. She had not seen Petitioner during the intervening six months. T. 78. Paul indicated her testimony was consistent with the statement she gave to the Travelers Insurance representative. T. 86. Paul testified she spoke with Petitioner's counsel shortly before the hearing. Petitioner's counsel alluded to an earlier conversation she claimed to have had with Paul. Petitioner's counsel tried to persuade Paul to testify differently than she actually did. T. 87-88.

In response to additional questions posed by Petitioner's counsel, Paul testified she did not recall having spoken with Petitioner's counsel in February. She did recall speaking with Petitioner's counsel by telephone. During that conversation, Petitioner's counsel told her she planned to serve her with a subpoena. T. 89-90. During her meeting with Respondent's counsel, Respondent's counsel showed her a driver's license and asked her if she recognized the person shown on the license. Paul did not recall receiving a call about the case at work in

late January or early February. T. 92. Paul testified that Petitioner's counsel did not tell her specifically what to say at the hearing but did make a suggestion as to what to say. T. 92-93. Petitioner's counsel told her to try to remember a conversation the two of them had in February. T. 94. When Petitioner called her, Petitioner did not tell her "you should testify for me." Instead, Petitioner told her that someone was going to call her and ask her a few questions. T. 95.

Suzanne Kohlberg testified on behalf of Respondent. Kohlberg testified she has worked for Respondent for fourteen years. She is currently Vice President of human resources. T. 98. She knows Petitioner. In her opinion, Petitioner is not a truthful person. T. 98-99. Respondent conducted an audit of five stores that Petitioner reported having visited for the purpose of training store employees. One store reported that Petitioner conducted training for only half an hour or an hour rather than the typical three or four hours. Another store reported that Petitioner kept rescheduling the training sessions and ultimately never appeared. Another store reported having no knowledge of the two employees Petitioner claimed to have trained. Respondent paid Petitioner for the training she claimed to have conducted. T. 100. The audit also revealed that Petitioner was accompanied by a large man at each store she serviced. T. 112.

Kohlberg identified RX 2 as a First Report of Injury. It is customary for Respondent to complete such a document if an employee calls in and reports a work injury. T. 100-101. Such documents are kept in the ordinary course of business. T. 101. Petitioner did not object to the admission of RX 2. T. 160.

Kohlberg testified that Petitioner reported her claimed injury to her in late October. Kohlberg asked Petitioner if anyone witnessed the injury. Petitioner indicated that two individuals, Lauren and Shawn, witnessed her injury. Kohlberg asked Petitioner if she knew the last name of either of these individuals. Petitioner said no. Petitioner indicated that Lauren is a WalMart employee and that Shawn "just happened to be at the store" doing work for Respondent. T. 102.

Kohlberg testified she telephoned Petitioner on November 12, 2012 and asked whether one of the two witnesses was Shawn Wheeler. Petitioner replied, "I don't know, it could have been." Petitioner was "very upset" by Kohlberg's question. At that point, Kohlberg said to Petitioner, "I don't think you are being completely honest with me." Kohlberg went on to say "we fully know that you know Shawn." Petitioner said she did not want to talk anymore and then hung up. T. 103.

Kohlberg testified that Petitioner was scheduled to conduct a "critical" training session on October 12, 2012, "very early in the morning." Petitioner did not conduct this session. Kohlberg conducted an investigation so as to determine why Petitioner failed to do this. Petitioner told Kohlberg she left her manager a voice mail message at 5:45 AM on October 12, 2012 indicating her rental car had broken down and she was thus unable to attend the session. Petitioner had the "800" number for the rental car agency on her key chain. Petitioner also had

access to the Internet via her Respondent-provided cell phone but made no attempt to contact the agency to get a different car. T. 105. Petitioner was "basically MIA" on the morning the training was to take place. For two or three hours, Petitioner did not respond to calls that managers placed to her cell phone and personal phone. When Petitioner finally responded, she indicated she was on the side of the road, that smoke was coming out of her car and that Triple A was en route. T. 106. Respondent later determined that Petitioner returned her rental car to the agency and made no mention of any problems with the car. Petitioner rents cars from this agency "all the time." The agency conducted a "test drive" and determined there were no problems with the car. T. 107.

Kohlberg testified that Petitioner subsequently resigned from Respondent because she "did not want to be grilled over [the] car incident." Petitioner was not pleased with the manner in which she was questioned. T. 108.

Kohlberg testified that Petitioner was transferred to a different division at one point, with that transfer resulting in "additional money." However, the transfer did not constitute a promotion. T. 109.

Kohlberg testified that Respondent did not learn of Petitioner's felony conviction until after Petitioner resigned. T. 110. At some point after Petitioner resigned, Petitioner called her and asked to have her job back. It was after Kohlberg refused to give Petitioner her job back that Petitioner mentioned her claimed injury to Kohlberg. T. 110. The E-mails that Petitioner sent to her supervisor, Troy Harnett, were the extent of what Respondent knew about Petitioner's injuries. Petitioner did not request medical treatment before she resigned. T. 111.

Kohlberg testified that Shawn Wheeler worked for Respondent in the past. Wheeler was not working for Respondent on September 21, 2012. T. 112-113. It is against Respondent's policy for an employee who is not assigned to a particular store to do work at that store. T. 115, 117. Respondent was not aware of Wheeler's felony conviction when Respondent hired Wheeler. T. 113. It was during the investigation that Kohlberg became aware of Petitioner's relationship with Wheeler.

Kohlberg identified RX 1 as part of Shawn Wheeler's personnel file. Respondent maintains the documents in RX 1 in the ordinary course of business. T. 118. The Arbitrator admitted RX 1 into evidence over Petitioner's foundational objection. T. 159.

Kohlberg testified she finds it "very odd" that the Application for Adjustment of Claim describes Petitioner as single. When she talked with Petitioner, Petitioner constantly referred to her "husband." Petitioner told Kohlberg that her husband returned the rental car. T. 119. Petitioner did not indicate that Shawn Wheeler returned the rental car. T. 119.

Under cross-examination, Kohlberg testified she was not involved in hiring Petitioner. T. 121. She supervises various human resources representatives. One of those representatives was in direct communication with Petitioner. T. 120. She does not know when the First Report

of Injury was completed. The First Report of Injury is undated, "which is unusual." T. 121. The individuals who conducted the store audits were Troy Harnett, Petitioner's direct supervisor, and Delores Wilson. Wilson is a manager who visited three of the stores. She provided some information that was used in the audits. T. 124. The audits were conducted a week or two after October 12, 2012. T. 123. Kohlberg testified she requested the audits because, at that point, Petitioner was "adamant" about wanting to "be able to continue" working for Respondent. T. 123. Kohlberg testified it is her job to gather all of the information to ensure that Respondent is making a good decision to either allow an employee a "second chance" or to "part ways" and accept an employee's resignation. T. 123. No one directed her to conduct the audits. T. 124. Kohlberg testified she has never met or talked with Shawn Wheeler. She was not involved in Wheeler's hiring. T. 125. Kohlberg did not talk with Petitioner on October 12, 2012. T. 127. Before October 12, 2012, Kohlberg had no dealings with Petitioner. T. 128. It is Respondent's policy to do a background check of each applicant. Kohlberg does not conduct these checks. One of the employees who works under Kohlberg does this. Respondent has about 5,000 employees so background checks constitute a full-time job. T. 129. To Kohlberg's knowledge, Petitioner never left Respondent's employment at any point prior to her resignation. If a Respondent employee has a gap in employment of one year or less, that employee is not considered a "re-hire" and no new background check is required. T. 129. Kohlberg testified that Petitioner told her she was injured while pulling out supplies. This conversation took place "during the First Report of Injury." T. 130. After Petitioner resigned, Kohlberg asked Petitioner to E-mail her all of the injury-related documents. T. 130-131. Petitioner E-mailed her something that indicated she was injured while pulling supplies. T. 131. Kohlberg testified it was Troy Harnett who drew Petitioner's felony conviction to her attention. T. 132. Kohlberg indicated that most of her interaction with Harnett took place after Petitioner resigned. T. 132. "During the First Report of Injury," Petitioner told Kohlberg she had previously reported her injury to Harnett on two separate occasions. T. 133. An employee in Petitioner's position would not report a work injury to her. An employee in Petitioner's position would report a work injury to his or her manager. T. 134.

On redirect, Kohlberg testified that the First Report of Injury reflects Petitioner saw a doctor on October 22, 2012. She thus estimates that the First Report of Injury was completed after October 22, 2012. T. 135. She thinks it was completed in late October but she is not positive. T. 135. She is an executive. Harnett is not an executive. T. 136. Michele Gohlke is a manager, not an executive. Collette Walton, who may be related to Petitioner, is not an executive. Erin Watkins, Tina Palermo, Stephanie Pollock, Jon Oliver, Dolores Wilson and Karen Santarossa are not executives. T. 138.

Under re-cross, Kohlberg acknowledged that, on October 23, 2012, she received and opened an E-mail that Petitioner sent to Troy Harnett. T. 143.

Respondent offered into evidence records from Dr. Bhan, an internist. Dr. Bhan's note of September 26, 2012 reflects that Petitioner was seen for purposes of a routine gynecological examination. The note contains no mention of any shoulder or arm complaints. In fact, the note states that Petitioner voiced no complaints. RX 3.

Respondent also offered into evidence a report authored by Dr. Fetter, an orthopedic surgeon, in which the doctor commented as to the reasonableness and necessity of Petitioner's treatment. The doctor described Petitioner's injury as a left shoulder strain. He opined that Petitioner reached maximum medical improvement on November 21, 2012 and needed only a home exercise program as of that date. RX 4.

Arbitrator's Credibility Assessment and Conclusions of Law

Was Petitioner credible? Did Petitioner establish a compensable work accident of September 21, 2012?

Petitioner was not confrontational or unpleasant. At times, however, she was far too ready to explain away inconsistencies. Those inconsistencies were not few in number.

Petitioner testified she "hollered" and "went down" after lifting an unexpectedly heavy box at a WalMart store on September 21, 2012. Lauren Paul, a WalMart employee who testified pursuant to subpoena, confirmed that Petitioner unloaded boxes at the store and warned her not to lift a particular box but denied that Petitioner cried out or gave any other indication of having been injured. Petitioner and Paul agree they were within six feet of one another on the day in question.

Petitioner testified she reported her injury to Troy Harnett, her regional manager, via phone on September 21, 2012 and via E-mail on the morning of September 22, 2012. The Arbitrator notes that Petitioner's E-mail of Saturday, September 22, 2012 (sent at 9:30 PM) does not "mirror" her detailed, dramatic testimony as to the events of September 21, 2012. Rather, it vaguely alludes to more than one occasion on which Petitioner experienced difficulty moving supplies. As for an injury, the E-mail simply states "I think I pulled a muscle" with no indication as to when or where this might have occurred. PX 1.

On direct examination, Petitioner testified she resigned under duress on October 12, 2012 and first sought treatment for her claimed injuries on October 22, 2012. Under cross-examination, Petitioner admitted seeing her internist, Dr. Bhan, on September 26, 2012, only five days after the claimed accident. Petitioner testified she told Dr. Bhan about her accident and injuries. According to Petitioner, Dr. Bhan stated she could not treat these injuries and directed Petitioner to see a "workers' comp" doctor. Dr. Bhan's note of September 26, 2012 contains no mention of a work accident or work-related injuries.

Petitioner acknowledged being convicted of felony arson in 2007, although she indicated she was "falsely accused" of this crime. The Arbitrator admitted RX 5, a Rule 23 order of March 16, 2011 affirming the conviction, into evidence over Petitioner's objection. In her proposed decision, Petitioner maintains that this ruling was erroneous and that her conviction is "wholly irrelevant to whether she sustained a work injury in 2012." In the Arbitrator's view,

evidence concerning the conviction is admissible pursuant to Supreme Court Rule 609 and relevant to the issue of credibility.

Having considered Petitioner's demeanor and weighed the foregoing, i.e., the variance between Petitioner's testimony and initial E-mail, the variance between Petitioner's and Paul's accounts, the variance between Petitioner's testimony and Dr. Bhan's note, and Petitioner's felony arson conviction, the Arbitrator finds that Petitioner was not credible and failed to prove a work accident of September 21, 2012. The Arbitrator clarifies that she gives no consideration to Kohlberg's testimony in making these findings. The Arbitrator views the remaining disputed issues as moot.

Compensation is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cynthia Henson,
Petitioner,

14IWCC0222

vs.

NO: 11 WC 10117

Chicago Transit Authority,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 21, 2013 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 27 2014
KWL/vf
O-3/17/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0222

HENSON, CYNTHIA
Employee/Petitioner

Case# 11WC010117

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

On 5/21/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0226 GOLDSTEIN BENDER & ROMANOFF
DAVID FEUER
ONE N LASALLE ST SUITE 2600
CHICAGO, IL 60602

0515 CHICAGO TRANSIT AUTHORITY
ARGY KOUTSIKOS ESQ
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

☐	Injured Workers' Benefit Fund (§4(d))
☐	Rate Adjustment Fund (§8(g)
☐	Second Injury Fund (§8(e)18)
☒	None of the above

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

14IWCC0222

CYNTHIA HENSON
Employee/Petitioner

Case #11 WC 10117

v.

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on April 17, 2013. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

A. ☐ Was the respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

C. ☒ Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent?

D. ☐ What was the date of the accident?

E. ☐ Was timely notice of the accident given to the respondent?

F. ☒ Is the petitioner's present condition of ill-being causally related to the injury?

G. ☐ What were the petitioner's earnings?

H. ☐ What was the petitioner's age at the time of the accident?

I. ☐ What was the petitioner's marital status at the time of the accident?

J. ☐ Were the medical services that were provided to petitioner reasonable and necessary?

K. ☒ What temporary benefits are due: ☐ TPD ☐ Maintenance ☒ TTD?

L. ☐ What is the nature and extent of injury?

M. ☐ Should penalties or fees be imposed upon the respondent?

FINDINGS

- On September 13, 2010, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $52,416.00; the average weekly wage was $1,008.00.
- At the time of injury, the petitioner was 48 years of age, *single* with no children under 18.
- The parties agreed that the petitioner received all reasonable and necessary medical services.
- The parties agreed that the respondent paid the appropriate amount for all the related, reasonable and necessary medical services provided to the petitioner.

ORDER:

- The petitioner's request for benefits is denied and the claim is dismissed.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Robert Williams

5/21/13
Date

MAY 21 2013

FINDINGS OF FACTS:

The petitioner, a rail custodian, had work duties on September 13, 2010, of cleaning the common areas, bathrooms, rail platforms, stairs, etc. and removing garbage at a rail station. She used cleaning solutions. The petitioner filed a written report of injury with the respondent the same day that her nose and throat was burning, her throat was congested and she was having a reaction. She received immediate care at Concentra and reported that while wearing a mask her nose and throat started to burn while disinfecting, emptying garbage and cleaning a bathroom and that now her sinuses were hurting. The petitioner described mild and aching pain on the bilateral maxillary sinuses exacerbated by dust without radiation and alleviated by rest. She denied shortness of breath, coughing or difficulty breathing. The doctor noted a pulse oximetry of 96% on room air, mild bilateral maxillary sinus tenderness, clear breath sounds bilaterally, clear auscultation and percussion in lungs and no rales or wheezes. The diagnosis was inhalation of gas, fumes or vapors and upper respiratory infection and the recommendation was the remainder of the day off and regular work the next day.

The petitioner saw her primary care physician, Dr. Maria Ignacio of Advocate Medical Group, on September 20th, who noted a prior history of intrinsic asthma and asthmatic bronchitis. The petitioner was asymptomatic and had clear lungs with no coughing or wheezing. The diagnosis was bronchial asthma. On October 15th, the petitioner felt well and requested a return to work with restrictions of no working with fumes or chemicals.

The petitioner reported frequent exacerbation of her asthma on April 27, 2011, and the doctor noted faint bilateral wheezes in her lung. At a pulmonary evaluation on

May 26, 2011, wheezing was noted in her right lower lung. Her lungs were clear at an evaluation on June 30, 2011, and August 1, 2011.

On August 24, 2011, the petitioner saw Dr. David Marder of the University of Illinois Medical Center, who noted that her pulmonary tests showed mild obstructive pulmonary impairment that were similar to previous tests on prior visits and subjective improved symptoms. The doctor recommended full-duty work and a NIOSH-approved respirator if she worked with cleaning agents that caused irritation. At an asthma follow-up at Advocate on October 18, 2011, a faint wheeze in her upper lung field was noted and at a pulmonary visit on October 20th, her peak flows were noted to be less than 80% of her personal best. On November 15, 2011, she reported emergency treatment for an asthma attack two days earlier. The doctor noted mild rhonchi in her lungs that were cleared with a cough.

On January 24, 2012, the petitioner sought treatment at Concentra for headaches and sinus pressure due to cold air from a respirator. Their assessment was acute sinusitis and regular activity was recommended. She sought treatment at Advocate on January 26, 2012, and was released to work. She followed up at Concentra on February 4 and 7, 2012. The petitioner followed up at Advocate on February 23, 2012, and March 15, 2012, and reported failing to comply with her maintenance inhaler and medication but denied having an asthma attack for a few weeks.

In a letter to the respondent, the petitioner stated that she was diagnosed with asthma in 1997. The records of Dr. Ignacio on September 20, 2010, indicate that she was following up for asthma. The petitioner applied for short-term disability for bronchial asthma on several occasions from August 11, 2009, through September 7, 2010.

FINDING REGARDING THE DATE OF ACCIDENT AND WHETHER THE PETITIONER'S ACCIDENT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH THE RESPONDENT:

Based upon the testimony and the evidence submitted, the petitioner failed to prove that she sustained an accident or an exacerbation of her pre-existing asthmatic condition on September 13, 2010, arising out of and in the course of her employment with the respondent. At her initial medical care at Concentra, the petitioner's complaints were limited to burning in her nose and throat and painful sinuses. She denied shortness of breath, coughing or difficulty breathing. The doctor noted a pulse oximetry of 96% on room air, mild bilateral maxillary sinus tenderness, clear breath sounds bilaterally, clear auscultation and percussion in lungs and no rales or wheezes. When the petitioner saw Dr. Ignacio on September 20th, she was asymptomatic and had clear lungs with no coughing or wheezing. In fact, the petitioner's report of injury to the respondent referred only to her throat and nose. The petitioner failed to prove that she had a work injury or an asthmatic attack/flare-up on September 13, 2010, or immediately thereafter.

Moreover, the petitioner had pre-existing intrinsic and bronchial asthma with periodic flare-ups or attacks due to unknown causes. The speculation as to the effect of the cleaning supplies on her asthma without more is not sufficient or persuasive. The petitioner's request for benefits is denied and the claim is dismissed.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

☒ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Andrea Kopsell,
Petitioner,
vs.

14IWCC0223

NO: 09 WC 38241

W. W. Henry Company,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue(s) of accident, medical expenses and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 7, 2013 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 27 2014
KWL/vf
O-3/17/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR

14IWCC0223

KOPSELL, ANDREA
Employee/Petitioner

Case# 09WC038241

W W HENRY COMPANY
Employer/Respondent

On 6/7/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0575 REGAS GUBBINS & REGAS
MATTHEW T GUBBINS
ONE DEARBORN SQ SUITE 300
KANKAKEE, IL 60901

0766 HENNESSY & ROACH PC
JOSEPH A ZWICK
140 S DEARBORN 7TH FL
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

# ILLINOIS WORKERS' COMPENSATION COMMISSION
# ARBITRATION DECISION
19(b)

14IWCC0223

Case # 09 WC 38241

Consolidated cases: N/A

Andrea Kopsell
Employee/Petitioner

v.

W.W. Henry Company
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert Falcioni**, Arbitrator of the Commission, in the city of **New Lenox**, on **May 16, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **1/26/2009**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$40,439.88**; the average weekly wage was **$777.69**.

On the date of accident, Petitioner was **52** years of age, ***single*** with **0** dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

The Arbitrator had determined that Petitioner has reached maximum medical improvement since June 16, 2010 and since the Arbitrator is denying Petitioner's request for prospective medical, no benefits are awarded at this time.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

May 24, 2013
Date

ICArbDec19(b)

JUN - 7 2013

STATEMENT OF FACTS

Petitioner testified that she worked as a filling operator on the alleged date of accident. Petitioner described that her job would involve operating a machine that filled cartridges with glue. Petitioner states that glue would end up on the floor in her area from time to time. She states that on January 26, 2009, her left foot got caught on some of the glue while she was turning. Petitioner states that she felt a popping sensation and pain in her left hip. After her initial visit at St. Mary's Hospital, Petitioner sought treatment at St. Mary's Occupational Medicine Clinic where she saw Dr. Panusczka. Petitioner states that she subsequently sought treatment with Dr. Michalow of Orthopedic Associates of Kankakee. Petitioner testified that Dr. Panusczka initially provided physical therapy. Dr. Michalow administered an injection to the left hip and referred Petitioner to Athletico for physical therapy. Petitioner testified that Dr. Panusczka and Dr. Michalow provided work restrictions of lifting limited to 20 to 30 lbs. Petitioner testified that Respondent did accommodate the restrictions.

Petitioner states that she eventually sought treatment with Dr. Charles Bush-Joseph. It appears from the records that her initial visit to Dr. Bush Joseph was for an IME requested by the Respondent. Petitioner indicates that Dr. Panusczka had suggested possible follow-up with Dr. Bush-Joseph. Petitioner notes that Dr. Bush-Joseph continued her restrictions and also recommended consideration of surgery to the left hip. Petitioner indicates that she wishes to pursue surgery.

Petitioner testified that she noticed a stabbing pain in the left hip area extending to her left knee. Petitioner reports that the pain has been consistent through-out the course of her treatment. Petitioner testified that she continued to work in a restricted

duty capacity, subject to the 20 to 30 lbs lifting restriction, from the date of accident up through a layoff which occurred on February 26, 2013. Following her layoff, Petitioner indicates that she has applied for "a couple" of positions but has not returned to employment. Petitioner acknowledged that her layoff was the result of a general layoff at Respondent's company.

Petitioner submitted as Exhibit Number 1, records from Provena St. Mary's Hospital. The records indicate that Petitioner was first seen on January 28, 2009, at which time she reported feeling a "pop" in her left hip when she turned and her left foot remained planted. Petitioner saw Dr. Panusczka at St. Mary's Occupational Medicine Clinic. Dr. Panusczka did recommend physical therapy which was also completed at St. Mary's Occupational Clinic and reflected in Petitioner's Exhibit Number 3. Dr. Panusczka initially provided a lifting restriction of 10 lbs.

On February 2, Petitioner reported some improvement and on February 9, Dr. Panusczka noted normal x-rays. Petitioner's diagnosis was listed as a sprain. On February 17, 2009, the therapy notes indicate weakness in the left hip. The notes of February 27 indicate that Petitioner as showing improvement. On March 2, Dr. Panusczka eased Petitioner's restrictions to 15 lbs but recommended an MRI on March 11. An MRI was completed on April 1, 2009, and interpreted as showing an increase in signal in what appeared to be the gluteus medius muscle tendon with a possible small amount of fluid within the bursa adjacent to the gluteus medius muscle and the greater trochanter of the hip consistent with a possible tear.

Petitioner followed up with Dr. Michalow who diagnosed a left hip abductor muscle strain with persistent greater trochanter bursitis. Dr. Michalow administered an

injection and stated that she could continue to work with a 15 lbs restriction. Dr. Michalow continued Petitioner's physical therapy at Athletico and Petitioner did note improvement on July 8 at which time her restrictions and diagnosis remained the same. On September 14, Dr. Michalow recommended a functional capacity evaluation which was completed on October 20. The functional capacity evaluation reported that Petitioner would be limited to 35 minutes with certain job functions and work conditioning was recommended.

Petitioner noted that she continued to receive treatment from Dr. Michalow until June of 2010, at which time she was discharged. On October 14, 2009, Dr. Michalow noted that Petitioner's restrictions had been eased to allow up to 50 lbs lifting. However, Petitioner stated that the increased activity level increased her symptoms. As of December 23, 2009, Dr. Michalow recommended work restrictions of 20 to 30 lbs lifting. Dr. Michalow recommended a repeat MRI which was completed on February 18 and interpreted as showing mild trochanter bursitis and a normal lift tensor facia lata and visualized IT band. Dr. Michalow indicated that the MRI findings were consistent with a lateral left hip trochanter bursitis but stated that the findings with regard to the rest of the exam were normal. On June 16, 2010, Dr. Michalow noted that Petitioner reported ongoing pain that was not progressing but not resolving. Dr. Michalow noted that Petitioner intended to see a physician at Rush.

Petitioner testified that she had seen Dr. Fletcher at Respondent's request. Petitioner submitted the records of Dr. Fletcher as Petitioner's Exhibits 7 and 8. The reports indicate that Dr. Fletcher evaluated Petitioner on June 4, 2009 and April 19, 2010. On June 4, 2009, Dr. Fletcher did recommend continued injections and

continued restrictions. On April 19, 2010, Dr. Fletcher recommended one more round of injections followed by aggressive rehabilitation. He further indicated that Petitioner would be considered at maximum medical improvement following that course of treatment.

Petitioner submitted as Exhibit Number 6, the records from Dr. Charles Bush-Joseph. Dr. Bush-Joseph first saw Petitioner on January 11, 2011, at which time he diagnosed chronic greater trochanteric bursitis of the left hip, probable partial interstitial tearing of the gluteus medial and IT band syndrome. At that time, Dr. Bush-Joseph suggested that surgery could be considered but noted that he did not see a greater than 60% to 70% chance of relieving Petitioner's discomfort through surgical intervention. However, Dr. Bush-Joseph also indicated that Petitioner could consider working through conservative measures. Dr. Bush-Joseph saw Petitioner again on September 13, 2012, at which time he again offered out-patient surgery. Otherwise, he indicates that she would be at maximum medical improvement.

Petitioner was also evaluated by Dr. Kevin Walsh at the request of the employer on April 17, 2012 and issued a report in connection with the evaluation. Dr. Walsh also issued an addendum on October 9, 2012 based upon review of additional records. Respondent submitted the reports of Dr. Walsh as Respondent's Exhibits Numbers 1 and 2, respectively. Dr. Walsh concluded that it was not at all likely that Petitioner's subjective complaints were related to a reported twisting accident in 2009. Dr. Walsh based his opinion upon the MRI of April 2002 that showed an increase signal in the gluteus medius with a possible small amount of fluid within the bursa adjacent to the medius and the greater trochanter, consistent with a possible tear. He notes that the

follow-up MRI in February of 2010 showed only a mild left trochanter bursitis without evidence of tenodesis, tendonitis, peritendinitis or tear in the gluteal. Finally, a third MRI reportedly showed no evidence of a tendon tear but severe left gluteal medius tendonisis and mild bilateral hip arthrosis. Dr. Walsh felt that Petitioner exhibited symptom magnification. He concluded that Petitioner did not require surgery and was able to return to regular employment. He also noted that the treatment Dr. Bush Joseph was recommending was to the gluteal ***minimus*** muscle, not the gluteal ***medial*** muscle, and was at a loss as to explain the discrepancy, as Dr. Bush Joseph had not explained his reasons for wanting to operate on a muscle that had never been indicated on any subjective or objective tests as being involved in Petitioner's condition.

Respondent submitted as Exhibit Number 3, a Utilization Review report by Dr. Robert Holladay noting that the surgery by Dr. Bush-Joseph was not certified.

Respondent's Exhibits 4 and 5 were job descriptions of Petitioner's regular job duties and the employment she worked in her accommodate position. Respondent's Exhibits Numbers 6 and 7 were the corresponding videos depicting Petitioner's regular employment and the modified position she worked following the accident. Petitioner agreed that the job description and job videos were accurate but noted that the job video depicted her pre-injury job in its current form. She noted that there were modifications made to the position that are not in the video. Specifically, Petitioner testified with regard to more significant walking around the machine that was previously required.

CONCLUSIONS OF LAW

In relation to (F) causal connection, the Arbitrator finds as follows:

It is stipulated that Petitioner suffered an accident while working on January 26, 2009. Petitioner reports that she noticed immediate pain in her left hip but continued working. Petitioner received treatment from Dr. Panusczka and Dr. Michalow. Respondent's prior evaluating physician, Dr. Fletcher, stated that Petitioner's condition at that time was related to the alleged accident. It is clear that Respondent is simply disputing causal connection with regard to Petitioner's ongoing complaints and alleged restrictions. However, based upon the opinions of Dr. Walsh, Respondent argues that Petitioner's condition and treatment is not related to the original accident. The Arbitrator does note that Petitioner reports ongoing pain in the left hip since the date of accident. However, Dr. Walsh explains that Petitioner exhibited symptoms magnification. Moreover, Dr. Walsh notes that the MRI in April of 2009 reported findings consistent with a possible tear. However, the MRI in February of 2010 demonstrated bursitis without evidence of tear. Dr. Walsh's opinions were supported by Utilization Review. The Arbitrator notes that Dr. Walsh's opinions as to medical causal connection are highly credible and based on all of the medical evidence extent in the present case, and the Arbitrator adopts same.

Based upon the entire circumstances, The Arbitrator finds that the Petitioner's ongoing complaints are not related to the alleged accident.

In relation to (L) temporary total disability, the Arbitrator finds as follows:

Petitioner alleges that she is entitled to TTD benefits from February 27, 2013 through the date of hearing of May 16, 2013. It is noted that Petitioner did continue to work in a lighter duty position until she was laid off on February 26, 2013. Petitioner agreed that she was laid off as part of a general economic layoff.. Petitioner would not currently be working in light of the economic layoff.

It is axiomatic that the threshold question with regard to whether or not Petitioner is entitled to temporary total disability is whether or not Petitioner's condition has stabilized. Petitioner's testimony was essentially that she has noticed pain in her left hip since the date of accident. Petitioner reports that there has been essentially no change in her symptoms. Dr. Michalow had previously discharged Petitioner in June of 2010, indicating that Petitioner was at maximum medical improvement at that time. Dr. Bush-Joseph has further conceded that Petitioner is at maximum medical improvement absent the surgery he has offered. (Dr. Bush-Joseph also notes that the surgery is not a guaranteed improvement and this is further addressed in prospective medical below).

It is noted that Dr. Panusczka reported in 2012 and 2013 that Petitioner would be subject to a sitting position with limited standing or walking. However, by Petitioner's own account, she was not limiting her employment to a sitting position only. Petitioner reported ongoing complaints that do not appear to change with her ongoing employment. It is noted that Dr. Bush-Joseph is the only physician that has discussed the possibility of surgery. Noting the findings set forth below, that the surgery proposed by Dr. Bush Joseph is not reasonable or necessary to cure or relieve the effects of Petitoner's injury, the Arbitrator finds that Petitioner has reached maximum medical

improvement, her condition is stabilized and she is not entitled to any TTD after the economic layoff of February 26, 2013.

In relation to (K) prospective medical, the Arbitrator finds as follows:

Notwithstanding any of the above findings, it is noted that Petitioner has expressed a desire to undergo surgery as recommended by Dr. Bush-Joseph. It was noted that Dr. Kevin Walsh disputes the need for the surgery. In reviewing the entire medical file, the Arbitrator notes that Petitioner saw Dr. Panusczka and Dr. Michalow prior to seeing Dr. Bush-Joseph. Neither Dr. Panusczka nor Dr. Michalow prescribed surgery for Petitioner. Dr. Bush-Joseph has seen Petitioner on only two occasions. On the very fist visit with Dr. Bush-Joseph, Dr. Bush-Joseph stated that surgery could be considered an option, "as a last resort." Dr. Bush-Joseph also notes that there was "no greater than" 60-70% chance of any relief with surgery. It is unclear as to whether or not Dr. Bush-Joseph actually reviewed the prior treating records. Dr. Walsh, on the other hand, did appear to review the medical records available at that time. Dr. Walsh noted that the review of the MRI scans show conflicting conclusions with regard to whether or not a tear was present. Moreover, the progression of the scans suggests actual improvement. Dr. Walsh also expressed concern in the fact that Dr. Bush-Joseph did not describe the type of surgery he intended to perform. Dr. Walsh also noted that Dr. Bush Joseph proposed to operate on a muscle that was never indicated on any test to be a problem, ie the gluteal minimal muscle. While it is noted that Dr. Bush-Joseph is a treating doctor and Dr. Walsh is an examining physician obtained under Section 12, it is equally true that both physicians have rendered their opinions after one visit. However, it is clear that Dr. Walsh had the benefit of the full medical chart. Moreover, the proposed surgery was evaluated by a Utilization Review by Dr.

Robert Holladay who concluded that the medical documentation does not support a recommendation for surgery.

As such, the Arbitrator finds that the surgery offered by Dr. Bush-Joseph is not reasonable and necessary treatment under the Workers' Compensation Act for this claim.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jerome George,

Petitioner,

vs.

NO: 09WC 14189

14IWCC0224

Abbington Rehab & Nursing Center,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, temporary total disability, maintenance, vocational rehabilitation, permanent total disability, medical expenses both current and prospective and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 16, 2013, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

14IWCC0224

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $18,700.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 7 2014
o031914
RWW/jrc
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR

GEORGE, JEROME
Employee/Petitioner

Case# **09WC014189**

14IWCC0224

ABBINGTON REHAB & NURSING CENTER
Employer/Respondent

On 9/16/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.03% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0274 HORWITZ HORWITZ & ASSOC
MARK WEISSBURG
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

1120 BRADY CONNOLLY & MASUDA PC
MATTHEW SHERIFF
ONE N LASALLE ST SUITE 1000
CHICAGO, IL 60602

14IWCC0224

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Jerome George
Employee/Petitioner

v.

Abbington Rehab & Nursing Center
Employer/Respondent

Case # 09 WC 14189

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **July 17, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☒ Maintenance ☐ TTD
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **nature and extent, vocational rehabilitation.**

FINDINGS

On the date of accident, **March 21, 2009**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$7,000.00**; the average weekly wage was **$400.00**.

On the date of accident, Petitioner was **54** years of age, ***married*** with **0** dependent children.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$34,005.75** for TTD.

ORDER

- Respondent shall pay for reasonable and necessary medical care and treatment as provided in Section 8(a) of the Act until 06-16-12.
- No prospective medical care is awarded after 06-15-12.
- Respondent shall pay Petitioner temporary total disability benefits of $ 266.67 per week for 56 weeks, commencing from 03-22-09 to 04-19-09, then from 06-20-09 to 11-24-09, then from 02-21-10 to 09-08-10, as provided in Section 8(b) of the Act.
- Respondent shall pay Petitioner maintenance benefits of $ 266.67/ week for 40 weeks, commencing on 09-09-10 through 06-15-12.
- No penalties are awarded in this matter.
- Respondent shall pay Petitioner permanent partial disability benefits of $ 360.00 week for 75 weeks, because the injuries caused the Petitioner 15 % loss of the person as a whole, as provided in Section 8(d)(2) of the Act.
- Petitioner is not entitled to vocational rehabilitation.
- The parties acknowledge a child support lien from the State of Illinois in the amount of $ 15,261.63.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

Date 09-15-13

ICArbDec19(b)

SEP 16 2013

Illinois Workers' Compensation Commission

Jerome George Case # **09** WC **14189**
Employee/Petitioner

v.

Abbington Rehab & Nursing Center
Employer/Respondent

I. FINDINGS OF FACT

On March 21, 2009, the petitioner, Mr. Jerome George, was working as a CNA for the respondent on a part-time basis. According to his testimony, the petitioner began working for Abbington Rehab for approximately one year prior to the accident. Petitioner testified that as he attempted to assist a patient using the Hoyer lift, Petitioner felt pain in his lower back.

The petitioner initially treated at the Schaumburg Treatment Center on March 21, 2009 and was diagnosed with a low back strain. Petitioner was reporting pain radiating to the right knee. It was also noted that he was suffering from drop foot on the right side which was an "old injury." Petitioner had a pre-existing drop foot.

The petitioner began treatment with Dr. Zindrick, whose notes on April 3, 2009 indicate that "Two years ago, the patient had episode of low back pain from a work-related injury." It was also noted that the petitioner has a prior history of tendon transfer in the right leg due to a traumatic injury, and continued to have atrophy, weakness and drop foot on the right side. The diagnosis at that time was acute low back pain, and the petitioner was referred for physical therapy. (Pet. Ex. 4).

The petitioner's therapy continued in late May and early June of 2009 and it was noted on June 9, 2009 that the petitioner was "no longer complaining of radiating pain into the left leg and pain overall is reduced 50%." (Pet. Ex. 4).

On July 20, 2009 the petitioner was seen by Dr. David Trotter for an independent medical examination at the request of the respondent. The doctor reviewed the medical records up to that point, and also conducted a physical examination of the petitioner. Following this examination the doctor rendered his opinion that the petitioner does appear to have suffered a soft tissue sprain/strain injury superimposed on pre-existing degenerative condition in his spine. Dr. Trotter was of the opinion that there was no longer any residual component from the March 21, 2009 injury and any problems the petitioner continued to experience were based on long-standing issues. The doctor also felt that the petitioner was at maximum medical improvement with regard to the March 21, 2009 accident and could return to work full duty. (Resp. Ex. 1).

Meanwhile, the petitioner was being accommodated on a light duty basis by the respondent from mid-April to late June of 2009; however, effective June 20, 2009 light duty was no longer available and the petitioner began receiving temporary total disability benefits.

On August 6, 2009 the petitioner returned to Dr. Zindrick for follow-up at which time the doctor had the opportunity to review the independent medical examination of Dr. Trotter and indicated that he disagreed with that opinion. Dr. Zindrick recommended continuing physical therapy and that the petitioner obtains an MRI scan for the lumbar spine.

The petitioner continued to have physical therapy at Advanced Rehabilitation Clinic in August of 2009, and noted some improvement, but still continued to complain of pain. (Pet. Ex. 2).

On August 26, 2009 the petitioner was seen by Dr. Stephen Bardfield at Hinsdale Orthopedics complaining of pain in his mid to low back region. Following the exam, the petitioner was diagnosed with discogenic low back pain at L5-S1 with central disc protrusions. The doctor then recommended a series of epidural injections.

On September 3, 2009 the petitioner returned to Hinsdale Orthopedics and was again seen by Dr. Zindrick, who reviewed the MRI and noted a "small central/rightward L5-S1 disc herniation." Dr. Zindrick recommended a series of epidural steroid injections and continuing therapy. Dr. Zindrick referred the petitioner to Dr. Simon Ho.

On September 9, 2009, Dr. Simon Ho wrote that petitioner had pain from 8/10 to 9/10, but without radiation

On October 1, 2009 the petitioner returned to Dr. Zindrick, stating his back pain was unchanged. It was also noted the petitioner was going to have a total knee replacement in October of 2009, something that all agree was unrelated to the incident of March 2009. Apparently, the petitioner's back treatment was going to be put on hold while the knee replacement surgery and rehabilitation took place. (Pet. Ex. 4).

On November 24, 2009 the petitioner returned to Dr. Zindrick following the total knee replacement indicating that his knee "felt great." Petitioner was still experiencing back pain which he would rate as a 7/10 and on examination Dr. Zindrick noted the petitioner now had a negative straight leg raise examination. The petitioner was requesting an attempted trial return to work in a CNA position, and the doctor still felt that although epidural steroid injections would be appropriate, he returned the petitioner to full duty work effective November 24, 2009.

Following this release, the petitioner returned to work on a full duty basis for Abbington Rehab and functioned in that capacity until late February of 2009. Meanwhile, the petitioner

also had a lumbar epidural steroid injection on December 17, 2009 by Dr. Daniel Cha, who noted that the petitioner had no radiation of symptoms down his lower extremities.

On February 24, 2010 the petitioner returned to Dr. Zindrick stating that the injection provided some relief; however, he was having fairly constant back pain. The doctor prescribed a second epidural injection and told his patient to continue to work without restrictions. (Pet. Ex. 4). There was an addendum office note issued February 24, 2010 which indicated that the petitioner was to have some restrictions, though could still function as a CNA.

On March 25, 2010 the petitioner presented to Dr. Wayne Kelly of Health Benefits Pain Management Services for the second lumbar epidural steroid injection.

On April 15, 2010, the Petitioner underwent an EMG performed by Dr. Kelly, which was abnormal, chronic and positive at L4-5. Dr. Kelly characterized the sensory/motor polyneuropathy as being of unclear etiology. The lumbosacral polyneuropathy as being related to the herniated disc.

The petitioner returned to Dr. Zindrick in April of 2010 where he was prescribed work restrictions of no prolonged standing/walking/sitting and no bending or lifting greater than 20 pounds.

On May 10, 2010 the petitioner returned to Dr. David Trotter for a second independent medical examination at the request of the respondent. Following his review of the medical treatment records from the time of his prior examination to that date as well as his personal physical examination of the petitioner, Dr. Trotter felt that it was "improbable" that the central disc herniation was caused or aggravated by the March 21, 2009 incident, and that there was no causal connection between his current complaints and the accident of March 21, 2009. The doctor also felt that any treatment rendered from his prior exam in July of 2009 to May of 2010

was not related to the original incident. The doctor felt that the central disc abnormality noted on the MRI does not correlate to petitioner's ongoing subjective or objective findings, and that there was evidence of significant symptom magnification. In addition Dr. Trotter was of the opinion that the petitioner should not be taking medications such as Oxycontin or Cymbalta. Dr. Trotter did feel the petitioner had some restrictions which would be appropriate; however, those would be related to his underlying condition and not the incident of March 2009. (Resp. Ex. 2).

On July 1, 2010, Dr. Kelly wrote that he did not recommend surgery, "especially given the fact that his symptoms are primarily localized lower back pain with no radicular compenent at this time at all."

The Petitioner underwent medical branch blocks, but did not enjoy long enough benefits to qualify for radio frequency ablations. Dr. Kelly placed the petitioner at MMI on September 9, 2010, stating that the petitioner would require long term pain management and the petitioner was to remain off work.

The petitioner's treatment then transitioned from Dr. Zindrick to Dr. Kelly to focus on pain management since the beginning of March 2011. On March 25, 2011 the petitioner presented to Dr. Kelly and received medial branch blocks on the left side at L3, L4 and L5. The doctor also renewed the ongoing prescriptions for Oxycontin and Hydrocodone.

On April 15, 2011 the petitioner returned to Dr. Kelly for additional medial branch blocks, and at that time the doctor recommended radiofrequency ablations.

On May 13, 2011 the petitioner presented to Dr. Kelly for follow-up indicating he was "doing about the same." The petitioner apparently did not want to pursue the radiofrequency ablations and that was not pursued by the physician. Petitioner was continued to be prescribed

Oxycontin and Hydrocodone and returning on a 1 month basis for essentially medication renewal.

On June 17, 2011 the petitioner returned to Dr. Kelly stating he was "doing well on the medications," however, the doctor wanted to wean the petitioner off of the Oxycontin and he was to transition to some sort of generic form of the same medication. (Pet. Ex. 5).

On July 15, 2011 petitioner returned to Dr. Kelly with essentially the same pain complaints and the same diagnosis. The medications including Hydrocodone and Morphine Sulfate were continued. Dr. Kelly found bilateral lower radiculopathies.

On November 3, 2011 the petitioner was examined by Dr. Steven Stanos at the Rehabilitation Institute of Chicago Center for Pain Management, upon the request of the respondent. Following his examination and the medical treatment records regarding the petitioner's treatment from the onset of the accident to that date as well as his personal examination of the petitioner, Dr. Stanos is of the opinion that the petitioner is suffering from chronic lumbosacral pain, and pursuant to the work history regarding the March 21st incident would be considered at least an exacerbation of his pre-existing condition, although that was somewhat unclear. The doctor was somewhat confused as to how the petitioner was being treated, as there was no objective evidence regarding facet joint issues as the petitioner was being treated, and a diagnosis of severe underlying sensory motor idiopathic polyneuropathy was not accurate. Since the petitioner was only experiencing mild reduction in pain and no significant functional improvement with the opioid therapy, the petitioner should be placed in some sort of interdisciplinary pain program to focus on functional restoration and return to work. The doctor outlined this program specifically at the end of which an FCE should be obtained. The doctor felt that those treatment recommendations that he outlined would be causally related to the

March 21, 2009 accident. The doctor also felt that the petitioner could at least return to a medium level of work based on his examination and possibly obtain an FCE for a higher level. Significantly, there was an addendum added to the report which reflected that the toxicology screen the petitioner took on November 3, 2011 in advance of the IME was negative for any opioids, despite the Oxycontin and Morphine the petitioner was being prescribed at that time. Due to the fact that the opioids were not really helping the petitioner either in his pain or his functional capacity, and now there is evidence suggesting that they were not even possibly being taken, the doctor recommended a discontinuing of that treatment. (Resp. Ex. 3).

The next day, Dr. Kelly stated that the petitioner has increased low back pain that radiates to the bilateral inguinal area, which is new and in additional to the bilateral lower extremity radiating pain. A repeat MRI was prescribed. (Pet. Ex. #5). A new bulging disc was found at L3-4 and additional epidural injections were prescribed to quite down the pain at that level.

On January 6, 2012, the petitioner achieved "modestly managed" maximum medical improvement with Dr. Kelly who stated that the petitioner will need long-term pain medication management with opiods. He will also need periodic injections and physical therapy. (Pet. Ex. #5)

On February 3, 2012, Dr. Kelly wrote that the petitioner's opiod medications were lost in the mail and that's why the drug screen test with Dr. Stanos was negative. (Pet. Ex. #5)

On March 2, 2012, Dr. Kelly wrote that his patient was stable and will see him once every three months unless a problem develops. The petitioner was required to come to the office to pick up the morphine sulfate every month. (Pet. Ex. #5) Nevertheless, a later prescription had a UPS tracking number on it. (Pet. Ex. #5)

On May 25, 2012, Dr. Kelly wrote a prescription for an FCE to determine petitioner's work capacity. (Resp. Ex. 4).

On June 15, 2012 the petitioner presented to ATI Physical Therapy for an FCE which was noted to be a valid representation of the petitioner's present physical capabilities. The therapist indicated that in his opinion the petitioner had reached the medium physical demand level, and the therapist noted that a CNA is typically considered a medium physical demand job. As a result, the petitioner could return to his previous position within those guidelines. (Resp. Ex. 5).

The petitioner returned to Dr. Kelly and Dr. Kelly was of the opinion that the FCE did not adequately demonstrate the petitioner's duties, nor did it adequately take into consideration the petitioner's subjective pain complaints as it failed grade the pain complaints. (Pet. Ex. 5). The doctor also indicated that petitioner had reached maximum medical improvement effective May 25, 2012 and can "only be maintained on his opioid medications."

The medical treatment records from his prior examination to the present date were sent to Dr. Stanos for comment and a record review report which he authored dated April 25, 2012. In his report, Dr. Stanos indicated that he reviewed the FCE and that it was legitimate, and that the petitioner should be released to work at least a medium strength level as detailed in that report. The fact that there was a negative urine toxicology connected to Dr. Stanos' previous examination of the petitioner and that there was no evidence of any positive toxicology screens conducted by Dr. Kelly, means that continued use of opioid medications with the petitioner were not appropriate. The doctor again recommended a program which would wean him off opioids and focus on functional capacity, as outlined in his prior report, and if that was not going to be attempted then no additional treatment would be necessary. (Resp. Ex. 6).

On August 3, 2012, repeat FCE was performed indicating that the petitioner could work only a sedentary work level.

The petitioner's treatment continued with health benefits and pain management services and significantly when the petitioner was seen by Dr. Alzoobi on October 29, 2012 the doctor again indicated that there was a negative urine toxicology screen from back in February, and that he was putting a hold on medications until they could obtain a more recent toxicology screen. In addition the doctor felt that the petitioner's back pain and condition was "rather moderate" and definitely questioned the need for Morphine and Hydrocodone as currently being prescribed. (Resp. Ex. 7).

Despite this, the petitioner has continued to treat with Dr. Kelly and Health Benefits Pain Management Services and continued to obtain medications on a monthly basis to today's date.

The respondent has suspended payment for the visits to Health Benefits Pain Management Services since the examinations of Dr. Stanos; however, has continued to pay for the medications as prescribed in order to avoid withdrawal issues of the petitioner.

The respondent also suspended temporary total disability benefits in the fall of 2012 based on the medical treatment records placing the petitioner at maximum medical improvement, as well as the FCE report and the opinions of Dr. Stanos and the previous opinion of Dr. Trotter.

On March 21, 2013, the petitioner reported to Dr. Kelly that his pain level was at 3-4/10 on a regular basis. Norco was prescribed. (Pet. Ex. #5)

II. CONCLUSIONS OF LAW

F. Is petitioner's current condition of ill-being causally related to the injury?

In support of the Arbitrator's finding that the petitioner's current condition is ill-being is causally related to the injury, the Arbitrator states as follows:

It is accepted by all parties that the petitioner suffered an incident on March 21, 2009 wherein he was attempting to lift a patient and when that patient lost his balance and fell, the petitioner suffered pain in his back. It was also without question that the petitioner had significant history of right foot drop which pre-dated that accident. The petitioner was treated with physical therapy by his treating physician Dr. Zindrick, and the respondent's independent examiner, Dr. Trotter, felt that the petitioner sustained a soft tissue injury as a result of this accident and that treatment beyond the first 8-10 weeks was no longer related to the incident itself.

Despite this, the petitioner has transitioned to a pain management program which has prescribed opioid medication for a number of years, despite the fact that the petitioner has experienced no significant benefit from pain management nor improved functional capacity.

The Arbitrator finds that the opinion of Dr. Stanos is controlling and most credible. Dr. Stanos found that causal connection was "at least an exacerbation of his pre-existing condition." (Tr. 18) and that the opioid medications, due to the fact that they are not helping the petitioner either in pain management nor in functional capacity, are no longer an effective treatment and should be discontinued.

The Arbitrator finds causal connection for the small, herniated disc at L5-S1 as a result of the accident of March 21, 2009. In noting this, the Arbitrator does not want to minimize the petitioner's injury and states that the MRI does show moderate to severe stenosis. However, no doctor has ever prescribed surgery, nor a pain pump. Petitioner did not want the radio frequency ablations. In contrast, Dr. Kelly's opinions are somewhat compromised by finding no

radiculopathy, then finding it months later and suggesting that it was always present. The petitioner's radiating symptoms to his inguinal groin area seem non-anatomic. The amount of narcotic medication and lack of meaningful monitoring of the same also create a cloud of uncertainty on the claim. The medical records state the medication was lost in the mail, but at trial, the petitioner stated that he had run out and had not taken them for only a day or two. Later, Dr. Kelly states he would no longer mail the medications to petitioner, but later, continued to do so. In all, it seems to Arbitrator that an unoperated herniated disc is not a severe enough injury to justify sedentary work restrictions, vocational rehabilitation and unending medical treatment including narcotic medications.

J. **Were the medical services that were provided to the petitioner reasonable and necessary? Has respondent paid all appropriate charges for all reasonable and necessary medical services?**

In support of the Arbitrator's finding that the medical services that have been paid by the respondent were reasonable and necessary, however the petitioner's current treatment is no longer reasonable and necessary the Arbitrator states as follows:

As indicated above, the Arbitrator finds that the initial treatment with Dr. Zindrick was appropriate, however that the continuing pain management is no longer appropriate and the treatment is not deemed reasonable and necessary based on the opinions of not only Dr. Trotter, but also Dr. Stanos.

The Arbitrator finds that the alleged unpaid medical bills presented by the petitioner at the hearing are reasonable, necessary and related to the incident of March 21, 2009, but only up the date of Dr. Stanos' Section 12 report, dated on June 15, 2012.

L. What temporary benefits are in dispute? (Maintenance)

In support of the Arbitrator's finding that the petitioner is no longer entitled to maintenance benefits, the Arbitrator states as follows:

It is agreed by the parties and contained in the trial stipulation sheets (Arb. Ex. 1) that the petitioner was temporary total disabled for a time period which was paid by the respondent, and also temporary partially disabled for a time which was also paid by the respondent.

A dispute arose following the petitioner's FCE which placed him at a medium level and allowed a return to work as a CNA, though the petitioner declined to pursue that return to work and has continued to remain unemployed.

The Arbitrator finds that the petitioner has reached maximum medical improvement and could find employment within his current restrictions; therefore maintenance benefits are no longer appropriate after June 15, 2012.

Petitioner's job search indicating that he responded to want ads that repeated responded "they did not have any phlebotomist position available," was not compelling. (Pet. Ex. #10) How can it be a "want ad" if no positions were open? It would seem that if the search was legitimate, it would include a search of places that were actually seeking a phlebotomist. Later, petitioner searched at places that were actually seeking a phlebotomist, but all wanted experienced applicants. Additionally, a legitimate job search would include different positions and job titles. No bona-fide effort was made to secure new employment.

M. Should penalties or fees be imposed upon the respondent?

In support of the Arbitrator's finding that no penalties or fees should be imposed upon the respondent the Arbitrator states as follows:

The petitioner alleges that the respondent should be liable for penalties and attorney's fees based on the suspension of maintenance benefits as well as the non-payment of selected medical bills.

As stated above, the Arbitrator finds that the medical bills in dispute are not reasonable, necessary, and related to the incident after June 15, 2012, and therefore are not the responsibility of the respondent. The respondent relied on competent medical testimony of both Dr. Trotter and Dr. Stanos to challenge these medical bills, and penalties under Sections 16, 19(k), or 19(l) are not warranted.

In addition, the Arbitrator finds that the suspension of TTD/maintenance benefits following the petitioner's release at maximum medical improvement and completion of the FCE is appropriate, and that the respondent has relied on competent medical testimony of Dr. Trotter as well as Dr. Stanos to suspend these benefits. The Arbitrator finds that penalties under Sections 19(k) and 19(l) or attorney's fees under Section 16 are not appropriate in this case.

Additionally, the Arbitrator finds the testimony of the Petitioner that several weeks or months of late payments to be far too vague and non specific in order to render an award.

O-1. Vocational Rehabilitation

In support of the Arbitrator's finding that the petitioner is not currently entitled to vocational rehabilitation, the Arbitrator states as follows:

It is noted in the medical treatment records as well as the independent examination reports and deposition transcripts submitted by both petitioner and respondent that the petitioner has reached maximum medical improvement. The petitioner's restrictions also appear to be in a position to be accommodated as a CNA, the petitioner's part-time position at the time of this incident, therefore vocational rehabilitation services appears unnecessary.

Due to the above, the Arbitrator finds that vocational rehabilitation services are not warranted in this case. Patsaves' conclusion that Petitioner has a learning disorder does not seem to fit with Petitioner's work history and testimony.

O-2. What is the nature and extent of the injury?

In support of the Arbitrator's finding that the petitioner has sustained 15% loss of man as a whole, the Arbitrator states as follows:

Although the petitioner and petitioner's attorney indicate that vocational rehabilitation should begin and that the case is not ripe for a nature and extent evaluation, the Arbitrator finds that nature and extent is appropriate at this time. The request for hearing sheet shows that nature and extent is a disputed issue at trial.

The Arbitrator has taken into account the medical treatment records as well as the independent medical examination reports and the deposition transcripts of those physicians, and has concluded that the petitioner has suffered a 15% loss man as a superimposed upon a pre-existing right foot drop and chronic polyneuropathy of unknown etiology.

09-15-13
Dated

Arbitrator Kurt Carlson

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gregory Donaldson,

Petitioner,

vs.

No. 11WC048159

14IWCC0225

Sangamon County Circuit Clerk,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, benefit rates, wage calculations, medical expenses, prospective medical care and temporary disability, and being advised of the facts and law, reverses the decision of the Arbitrator for the reasons stated below.

FACTS

Pre-accident medical records show that Petitioner began treating with Dr. Gary Rull, his primary care physician, on July 30, 2007. Petitioner reported having residual abdominal pain from infectious colitis as well as diabetes. Petitioner continued to treat for abdominal pain and other digestive problems through 2011.

A written warning form dated October 25, 2011, and signed by Petitioner and Ms. Cook states that the warning was given for "[l]ack of progress in learning job skills." The form also states that the warning was a follow up to a meeting held on October 14, 2011, and it established

several goals for Petitioner to meet by November 10, 2011. Additionally, the form states: "[i]f you do not meet these goals, I will be forced to recommend that you be terminated from your position."

An Employer's First Report of Injury form dated November 1, 2011, states that at 4:20 p.m. on October 31, 2011, Petitioner "lifted and carried a case of paper," and twisted his back when he "[p]icked up and turned with the case of paper."

On November 3, 2011, Petitioner treated with Dr. Andrew Varney, Dr. Rull's associate. Petitioner complained of back pain after a work injury and reported that on October 31, 2011, he "lifted a 60 lbs box while rotating." Since then, Petitioner experienced lower back pain, mostly left-sided numbness, muscle spasms and a tingling sensation in his big toes. On examination, Petitioner had a positive straight leg raise test on the right as well as right leg dyesthesia in the S1 distribution. Dr. Varney diagnosed Petitioner with lumbar back pain with radiculopathy, noted that Petitioner likely had S1 nerve radiculopathy, prescribed medication, recommended that Petitioner begin physical therapy and follow up with Dr. Rull and placed Petitioner off work for two days.

On November 10, 2011, Petitioner returned to Dr. Varney and reported that his lower back pain had not improved and he was not scheduled to begin physical therapy until the end of December. Dr. Varney reiterated his diagnoses from the previous appointment and recommended that Petitioner follow up with Dr. Rull.

On November 16, 2011, Petitioner treated with Dr. Rull and reported having persistent lower back pain, sometimes rated ten out of ten. Petitioner noted that his physical therapy appointment was scheduled for November 21, 2011, and he was unable to return to work. Dr. Rull concurred with Dr. Varney's diagnosis, prescribed Cyclobenzaprine and instructed Petitioner to go to the emergency room if his symptoms worsened or if he developed red flag symptoms.

On November 17, 2011, Dr. Rull called Petitioner and recommended that he undergo an MRI as Petitioner continued to complain of severe lower back pain. On November 18, 2011, Petitioner underwent a lumbar spine MRI which showed moderately severe spinal stenosis at L3-L4, secondary to a disc bulge with a possible focal disc herniation; edema in the L3 and L4 vertebral bodies which suggested the presence of microfractures; and moderate spinal stenosis at L2-L3. That day, Dr. Rull called Petitioner and recommended that he go to the hospital for pain control and a consultation with a spine surgeon that night. Despite Dr. Rull's warnings about possible permanent damage if his disc herniation created more pressure on the spinal cord, Petitioner decided to go to the hospital the next morning.

On November 19, 2011, Petitioner went to Memorial Medical Center and reported having severe back pain since lifting a box on Halloween. Petitioner indicated that he had similar back pain several years ago that resolved with steroid injections. Dr. Mark Eilers, an orthopedic spine surgery fellow with Dr. Per Freitag, examined Petitioner. Petitioner reported having lower back

pain since lifting a box at work on October 31, 2011. Dr. Eilers reviewed the lumbar spine MRI and noted that is showed an acute disk bulge at L3-L4 with significant narrowing of the canal; a significant amount of increased signal changes at L3-L4 suggestive of an acute injury; and disk bulging at L4-L5 and L5-S1 with associated canal narrowing and foraminal stenosis at L3-L4, L4-L5 and L5-S1. Dr. Eilers diagnosed Petitioner with an acute ruptured disk at L3-L4 and strongly recommended that Petitioner consent to being admitted overnight for pain control and observation. Petitioner refused to be admitted and Dr. Eilers prescribed a Medrol Dosepak, and recommended that he return to the emergency room if his symptoms worsened and keep his physical therapy appointment as long as the therapist was certified in McKenzie exercises.

On November 29, 2011, Petitioner returned to Dr. Rull and reported that he went to the emergency room three days before because he had worsening lower back pain and a "transient episode of right foot drop." Since then, he had experienced three episodes of right foot drop. Petitioner rated his pain as eight to eleven out of ten.

On December 8, 2011, Petitioner returned to Drs. Freitag and Eilers and reported that "on November 1, 2011, [sic] he was at work and attempted to pick up a box of papers. He was carrying several rims [sic] of paper and he reports that he had back pain instantly and has since had continued back pain and bilateral lower extremity weakness." Petitioner also reported having a couple of episodes where his right foot dropped, meaning that he was unable to keep it dorsiflexed while walking. Dr. Freitag diagnosed Petitioner with back pain and radiculopathy, and recommended that he continue physical therapy and undergo EMG studies to localize which nerve root was most affected.

On February 2, 2012, Petitioner returned to Dr. Rull and reported that his pain had not improved with physical therapy. Dr. Rull recommended that Petitioner follow up with Dr. Freitag. On March 12, 2012, Petitioner underwent EMG/NCV studies that showed bilateral, moderate lumbosacral radiculopathy of the L4, L5 and S1 nerve roots, with predominant involvement at L5; as well as mild sensory neuropathy in the lower extremities which was probably diabetic neuropathy.

On March 21, 2012, Dr. Freitag reviewed the EMG/NCV studies, noted that they showed bilateral L4-L5 and S1 radiculopathy, and recommended that Petitioner undergo a right L5 transforaminal lumbar epidural steroid injection. On May 8, 2012, Petitioner underwent a lumbar epidural steroid injection. Petitioner followed up with Dr. Freitag on May 30, 2012, who noted that Petitioner had a "marked setback," developing a severe headache, nausea and vomiting after the injection. Dr. Freitag noted that the injection appeared to have no effect on Petitioner's pain and recommended that he undergo a foraminal decompression surgery.

On June 18, 2012, Dr. David Lange, an orthopedic surgeon, performed a section 12 examination of Petitioner at Respondent's request. Dr. Lange noted that Petitioner was an information service clerk who sustained an injury "when he 'went to pick up a box of paper' on October 31, 2011." Petitioner stated that the box weighed 60 to 70 pounds and "'as soon as [he] turned, [he] knew something was wrong.'" Dr. Lange also noted that Petitioner dropped the box

to the floor. Additionally, Dr. Lange noted that Petitioner denied having prior symptoms and took Hydrocodone for several years for long standing colitis. Dr. Lange diagnosed Petitioner with mechanical low back pain on the right, "currently without a specific anatomic location," bilateral lower extremity symptoms, chemical dependency, premorbid psychological disease and occupational stressors. Dr. Lange opined:

> "It would appear to be impossible today to suggest his subjective complaints are definitely related to an October 31, 2011 work-related incident. Getting beyond the faulty nature of his past history and chronic chemical dependency, Mr. Donaldson today suggested he actually had **dropped** a '60-70 pound' box when he felt discomfort upon rotating. This history does not appear in the medical records most concurrent with the alleged incident. It must also be remembered one of the more common somatic complaints in individuals with premorbid psychological disease (particularly anxiety and depression) is low back pain.
>
> ***
>
> Although a decompressive procedure has been offered, the clinical examination of Mr. Donaldson is extremely benign from an objective point of view. Any 'findings' are actually positive Waddell in nature. Offering surgery for such subjective clinical findings would be fraught with uncertainty."

On June 25, 2012, Dr. Lange generated an addendum to his June 18, 2012, section 12 report. Dr. Lange reviewed plain x-rays of the lumbar spine dated December 8, 2011, as well as Petitioner's November 18, 2011, lumbar spine MRI. Dr. Lange opined that the x-rays showed "severe multilevel degenerative changes over essentially the entire lumbar spine," and the MRI findings were consistent with the x-rays. Dr. Lange concluded that the x-rays and MRI did not change his opinion on the issue of causation.

On July 12, 2012, Dr. Lange generated another addendum to his June 18, 2012, section 12 report. Dr. Lange reviewed a job description "presumably applicable to Mr. Donaldson," and a DVD of surveillance pictures, presumably from October 31, 2011. Dr. Lange noted that the DVD showed "intermittent surveillance every few seconds." Dr. Lange stated that two contiguous surveillance photographs showed Petitioner beginning to grasp a box and carrying it. Dr. Lange opined that "[t]here is nothing about his facial expression while he was carrying the box to suggest any immediate symptoms. There is also, nothing to suggest he 'dropped it to the floor.'" Lastly, Dr. Lange noted that one photograph showed Petitioner walking out of view with his right hand behind his back. Dr. Lange opined: "[w]hat this might conceivably mean cannot be stated from this single photo. A review of the surveillance today does not substantiate the mechanism of injury claimed by Mr. Donaldson."

On July 16, 2012, Petitioner returned to Dr. Rull whom he had seen about once per month since October 31, 2011. Petitioner reported having continued lower back pain. Dr. Rull noted that Petitioner was likely physically dependent on narcotics due to his chronicity of use.

At his November 1, 2012, deposition, Dr. Lange testified that the diffuse lower extremity symptoms that Petitioner complained about were typically seen in people with peripheral neuropathy caused by diabetes but noted that he was unaware of Petitioner having a history of diabetes. Dr. Lange noted that Petitioner's EMG/NCV studies showed peripheral neuropathy, which could explain Petitioner's complaints of lower extremity numbness. On cross-examination, Dr. Lange acknowledged that hypothetically, lifting a box weighing about 50 to 60 pounds and twisting could cause an exacerbation of underlying degenerative disc disease. Dr. Lange also acknowledged that Petitioner's symptoms were consistent with the MRI findings.

On November 2, 2012, Dr. Freitag performed a lumbar decompression at L4-L5 and L5-S1 bilaterally with a laminotomy and partial facetectomy. On November 14, 2012, Petitioner returned to Dr. Freitag and reported that he had less back pain and his leg pain had improved. Dr. Freitag removed Petitioner's staples and recommended that he begin hydrotherapy.

At his December 3, 2012, deposition, Dr. Freitag, an orthopedic surgeon specializing in spine surgery, opined that the focal disc herniation at L3-L4 was not degenerative and was "directly related to his trauma." However, the narrowing at all levels likely predated the October 31, 2011, injury. Dr. Freitag also opined that Petitioner's symptoms on December 8, 2011, were not consistent with a focal disc herniation at L3-L4 as his symptoms were below the L3-L4 area. An individual such as Petitioner can have degenerative disc disease and be asymptomatic. Petitioner's EMG/NCV studies showed two sources of nerve involvement: bilateral and moderate lumbosacral radiculopathy of the nerve roots at L4, L5 and S1; and some mild sensory neuropathy which was most likely diabetic neuropathy. Dr. Freitag's clinical findings were consistent with the EMG study results, especially at L5, as Petitioner had complaints of weakness in his big toes. Dr. Freitag opined that the diabetic neuropathy did not play a role in Petitioner's presentation of symptoms on December 8, 2011. Dr. Freitag recommended that Petitioner undergo surgery to improve his radiculopathy and because conservative treatment had failed. Lastly, Dr. Freitag opined that the work accident of picking up a box and twisting exacerbated Petitioner's preexisting degenerative changes, which were previously asymptomatic.

On December 18, 2012, Mr. Charlie Stratton, Respondent's human resources director, sent Petitioner a letter stating that his employment with Respondent had been terminated as of December 17, 2012. A work status note from Dr. Rull's office dated February 4, 2013, shows that Petitioner was released to work with restrictions of no lifting greater than 50 pounds and no repetitive bending or twisting activities.

At the February 7, 2013, section 19(b) arbitration hearing, Petitioner testified that he began working for Respondent in September of 2011. Petitioner's job consisted of inputting data and scanning mail. When he first began working for Respondent, Petitioner experienced upper back tightness from sitting at his desk for about six hours each day. Petitioner was not used to sitting for a long period of time and he would lie on the floor at work and pop his back a few times each day for the first three weeks that he worked for Respondent. Petitioner had a difficult relationship with his supervisor, Ms. Debbie Cook, who would "berate" him publicly about data entry errors and exclude him from office functions.

About seven to nine years before October of 2011, Petitioner treated with Dr. Paul Smucker for lower back problems and Petitioner underwent two epidural injections. Petitioner testified that "[he] was fine," after the injections. Dr. Rull has been Petitioner's primary care physician since July of 2007 and Petitioner did not seek treatment for lower back problems or have lower back pain until October 31, 2011. Prior to the same date, Petitioner took Hydrocodone for unresolved colitis, which he continued to take for back pain after the date of injury. Between July of 2007 and October of 2011, Petitioner helped his two sons move about four times.

At some point prior to October 31, 2011, Mr. Chase Short, one of Respondent's assistant managers, instructed Petitioner to make sure that the printers were filled with paper in the afternoons. On October 31, 2011, Petitioner began to refill the printers with paper and noticed that he did not have enough paper. Petitioner went to the hallway at the entrance of the office where Respondent kept 60 pound boxes of paper and "grabbed a box." Petitioner explained that he "turned and when [he] turned and took a step [he] just thought, oh, this doesn't feel right and as [he] kept walking [he] just felt a little more uncomfortable and when [he] got to the table [he] just dropped the paper instead of placing it down, the box." Petitioner described the mechanism of injury further and stated that he picked up the box and twisted. Petitioner also stated that he initially experienced back pain just below the belt line which seemed to radiate down his thighs and calves.

Petitioner testified that there is a camera, which takes pictures every six to seven seconds, located in the hallway where Respondent stores the paper. It is used as a time clock to take pictures of Respondent's employees when they come and go from work. Petitioner reviewed some photographs taken from the time clock camera on the day of the injury. Petitioner testified that photograph number two showed him picking up the box of paper by some plastic straps and photograph number three showed him with his body turned toward the camera. Petitioner twisted his body at some point between the time that photographs two and three were taken. Petitioner described photograph number six as a shot of him "pushing against [his] back because it's uncomfortable."

After the accident, Petitioner went home and his back pain worsened overnight. The next morning, Petitioner reported the injury to Ms. Cook as he could not stand up or sit well and could not sleep due to lower back pain. Respondent terminated Petitioner's employment on December 18, 2012. Leading up to his back surgery, Petitioner could not sit without having radiating pain in his calves and he could not walk up and down stairs. Petitioner testified that since the surgery, he has been "100 percent" and he no longer has radicular symptoms. Currently, he can walk up and down stairs and his back pain is better. As of the arbitration hearing, Dr. Freitag had not released Petitioner to full duty work and Petitioner continued to undergo water therapy.

On cross-examination, Petitioner testified that on October 31, 2011, he did not feel he needed immediate medical attention because he thought his back would improve in one or two days, and he was able to go home shortly after he injured his back as the injury occurred about five to ten minutes before the end of his shift. Petitioner acknowledged that prior to the date of

accident, his coworkers knew he had some upper back pain because they saw him lie down on the floor and pop his back.

Mr. Chase Short, one of Respondent's assistant managers, testified on Respondent's behalf. Within the first two weeks of Petitioner's employment with Respondent, Mr. Short saw Petitioner lie on the floor and Petitioner stated that his back hurt but did not specify which part of his back hurt. Around 4 p.m. on October 31, 2011, Petitioner asked Mr. Short where he could find copy paper. Subsequently, Mr. Short saw Petitioner walk into the room with a box of paper but Petitioner did not demonstrate facial expressions or behavior indicating that he was in pain, and did not complain of pain. Mr. Short agreed that he told Petitioner to make sure the printers were filled with paper but he also stated that reams of paper were always kept under a table across from the printers. Mr. Short can see the printers and the table across from the printers from his desk and he did not see Petitioner drop the box of paper. On cross-examination, Mr. Short acknowledged that he saw Petitioner carrying the box of paper for less than "a couple seconds." Mr. Short did not see Petitioner put down or drop the box of paper.

Ms. Deborah Cook, Respondent's scanning and data entry supervisor, testified on Respondent's behalf. Ms. Cook testified that Petitioner's performance was "not up to standard" and prior to the alleged accident, she spoke to Petitioner about the problems with his work. On October 25, 2011, she gave Petitioner a written warning, establishing goals for Petitioner to meet. One week later, Petitioner had not met the goals set out in the written warning, and he continued to have a high rate of data entry errors and did not produce as much work as the other clerks. Prior to the alleged accident, Petitioner complained of having back pain and a "bad back" but did not specify which part of his back hurt. On cross-examination, Ms. Cook acknowledged that at no point prior to the date of the alleged accident did Petitioner demonstrate behavior that would be consistent with having lower back pain.

Mr. Stratton testified on Respondent's behalf. Mr. Stratton testified that on October 3, 2012, he saw Petitioner at a grocery store, carrying two plastic bags that appeared to be heavy because "he appeared to be having some difficulty - - he was carrying them as if they were heavy and the bags appeared to be strained."

The Commission reviewed nine photographs taken on October 31, 2011, which were admitted into evidence. At the section 19(b) arbitration hearing, Petitioner testified that he is the man depicted in the photographs. Photograph number one shows Petitioner in a hallway in front of a stack of boxes. Photograph number two shows Petitioner holding two plastic straps that are around one of the boxes. Photograph number three shows Petitioner holding the box by the plastic straps with his arms bent and the box at stomach-level. Photograph number four shows Petitioner walking in the opposite direction than he was before with an empty box in one hand. Photograph number six shows Petitioner walking in the direction he had been walking in the third photo with his mouth open and his right hand behind him, seemingly touching his lower back.

14IWCC0225

DISCUSSION

The Arbitrator found Petitioner proved by a preponderance of the evidence that he sustained an accident arising out of and in the course of his employment with Respondent on October 31, 2011. The Commission disagrees.

Petitioner failed to prove that he sustained a compensable work accident on October 31, 2011. Petitioner testified that when he first began working for Respondent in September of 2011, he experienced upper back tightness from sitting at his desk for about six hours each day. Petitioner would lie on the floor at work and pop his back a few times each day. Mr. Short testified that within the first two weeks of his employment, he saw Petitioner lie on the floor and Petitioner told him that his back hurt. Ms. Cook testified that prior to October 31, 2011, Petitioner complained of having back pain and a bad back. The Commission finds it significant that Petitioner had persistent complaints of back pain prior to the alleged work accident. Petitioner's testimony that he only had upper back pain prior to the accident is not credible or persuasive. The Commission also notes that Petitioner did not report a lower back injury on the alleged date of accident. Based upon the inconsistencies in Petitioner's testimony, the inconsistencies in the medical records and the totality of the record presented before the arbitrator, the Commission finds that Petitioner has failed to prove his case by a preponderance of the evidence.

IT IS THEREFORE ORDERED BY THE COMMISSION that the decision of the Arbitrator filed on March 14, 2013, is hereby reversed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

No bond is required for removal of this cause to the Circuit Court by Respondent. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 8 2014
MB/db
o-01/29/14
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Michael J. Brennan

Charles J. DeVriendt

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR

DONALDSON, GREGORY
Employee/Petitioner

Case# 11WC048159

14IWCC0225

SANGAMON COUNTY CIRCUIT CLERK
Employer/Respondent

On 3/14/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

2217 SHAY & ASSOCIATES
TIMOTHY SHAY
1030 S DURKIN DR
SPRINGFIELD, IL 62704

RUSIN MACIOROWSKI & FRIEDMAN LTD
MARK COSIMINI
2506 GALEN DR SUITE 104
CHAMPAIGN, IL 61821

14IWCC0225

TATE OF ILLINOIS)
)SS.
COUNTY OF Sangamon)

- ☐ Injured Workers' Benefit Fund (§4(d))
- ☐ Rate Adjustment Fund (§8(g))
- ☐ Second Injury Fund (§8(e)18)
- ☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Gregory Donaldson
Employee/Petitioner

v.

Sangamon County Circuit Clerk
Employer/Respondent

Case # 11 WC 048159

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Springfield**, on **February 7, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **10/31/2011**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned $**26,000.00**; the average weekly wage was $**500.00**.

On the date of accident, Petitioner was **56** years of age, ***single*** with **0** dependent children.

Respondent *has not* paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $15446.46 for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $15446.46.

Respondent is entitled to a credit of $**$14,492.06** under Section 8(j) of the Act.

ORDER

Temporary Total Disability

Respondent shall pay Petitioner Temporary Total Disability benefits of $289.59/week for 65 and 1/7 weeks, commencing 11/3/2011 through 11/4/2011 and 11/11/2011 through 2/7/2013, as provided in Section 8(b) of the Act.

Medical Bills

Respondent shall pay Petitioner's outstanding medical bills, directly to the providers, according to the Medical Fee Schedule adopted, as set forth in Section 8(a) of the Act.

Respondent shall be given credit for $14,492.06 for medical benefits paid by Blue Cross/Blue Shield under Section 8(j) of the Act. Respondent shall indemnify and hold Petitioner harmless against any claim made by Blue Cross/Blue Shield for collection of any medical bills granted credit for under Section 8(j) of the Act. Specifically, the Respondent shall settle the liens of Blue Cross/Blue Shield set forth in Petitioner's Exhibits #22 and #23.

Respondent shall reimburse the Petitioner for out-of-pocket medical expenses in the amount of $582.26.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

D. Ryan McCarthy
Signature of Arbitrator

March 11, 2013
Date

ICArbDec19(b)

MAR 14 2013

ADDENDUM

In support of the Arbitrator's Decision with respect to issues (C), Accident, and (F), Causal Connection, the Arbitrator finds the following facts:

The Petitioner was a single, 56 year-old man on the date of his accident. He was employed by the Respondent, Sangamon County Circuit Clerk's office. Seven to nine years before he began working for the Respondent he received two epidural injections from Dr. Paul Smucker for lower back pain. The Petitioner testified that after those epidural injections, he did not experience any lower back pain until October 31, 2011, his date of accident.

Dr. Gary Rull has been the Petitioner's primary care physician since July 30, 2007. Dr. Rull's pre-accident records were entered into evidence at Petitioner's Exhibit # 4. The Petitioner's last visit with Dr. Rull before the accident was October 17, 2011. None of the Petitioner's pre-accident records indicate that the Petitioner suffered lower back pain during the period of July 30, 2007 to October 17, 2011 nor was any treatment given for lower back pain during that period. (Px. 4)

The Petitioner testified that during the years prior to his accident, he moved several times and helped his two sons move as well. He also testified that he was involved in other physical activities during that period.

The Petitioner testified that he began working for the Respondent on September 19, 2011. His supervisor at his job with the Respondent was Debbie Cook. He indicated that he worked in the basement level of the Circuit Clerk's office in the information services department. He testified that he was not given his job description until three or four days before he was placed under an off duty work restriction. However, he did testify that his job required data input and scanning.

The Petitioner testified that he spent six and a half hours per day at his desk. He testified that when he first started, he was not used to sitting for that length of time and his upper back would get tight. To alleviate the stress to his upper back, he would lay on the floor to pop his upper back. After his third week working for the Respondent, he no longer had tightness in his upper back and did not need to pop it anymore.

The Petitioner testified that boxes of printer paper were kept in the entrance hallway of the basement level. He testified that there were approximately 20 to 30 boxes and that they weighed approximately sixty pounds. The Petitioner testified that he was told by Chase Short, the assistant manager, that he needed to make sure that the printers were filled with paper after he ran his reports at 4:15 p.m. so that the printers would not run out of paper when the 4:30 p.m. reports were run.

The Petitioner testified that on October 31, 2011, while he was at work, the print station ran out of extra paper. In order to refill the printers after he ran his reports, as he had been instructed to do by Mr. Short, he went out into the hallway and picked up a box of paper. He testified that he turned, took a step, and felt discomfort in his lower back. He testified that he continued walking to the print station, and as he walked his back became more and more uncomfortable. He testified that when he finally reached the print station he dropped the box of paper because he was so uncomfortable.

The Petitioner was presented with a series of still shots taken from a security camera in the hallway where the accident occurred. These stills were included in Respondent's Exhibit # 3, the evidence

deposition of Dr. Lange, as Petitioner's Deposition Exhibit # 3. The Petitioner testified that he had seen the surveillance film. Photograph number two depicted him lifting a box of paper, while photograph number 3 shows his body turned toward the camera. (Rx 3, PDEx 3) The Petitioner testified that in the time between when the two photographs were taken, he had twisted his body. Photograph number 6 depicts the Petitioner reaching behind his body toward his back. (Rx. 3, PDEx 3) The Petitioner testified that at that time, his back was not comfortable and that he was pushing on his back trying to relieve his pain.

The Petitioner testified that after the incident, his back did not feel right. He indicated that his back pain was right below the belt line, and that it radiated down both of his thighs and calves into his feet. However, he testified that he did not immediately report the accident. He ultimately reported the accident to Debbie Cook in her office the next morning on November 1, 2011. He reported that he was picking up a box of paper before he left the day before, had hurt his back, and that the pain had gotten increasingly worse over the course of the evening.

The Petitioner presented to Dr. Rull's office at Southern Illinois University School of Medicine on November 3, 2011. He was seen by Dr. Andrew Varney, another physician in the office, because Dr. Rull was out of town. The medical Records from Dr. Rull's office were entered into evidence as Petitioner's Exhibit # 5. The Petitioner testified that in the three days prior to his appointment with Dr. Varney, he noticed that he could not stand up or sit well, that he hurt, and that he was having trouble sleeping.

Dr. Varney indicated that the Petitioner reported back issues starting while he was at work and lifted a 60 pound box while rotating and since had lower back pain, numbness mostly on the left side, muscle spasms, and a tingling sensation down to the level of his bit toes. (Px. 5) Upon physical examination, Dr. Varney noted a positive straight leg test on the right side, that the Plaintiff found it painful to walk on his toes, and that he had dysesthesia on the right leg in the S1 distribution. (Px. 5) Dr. Varney diagnosed the Petitioner with lumbar pain with radiculopathy. (Px. 5) He referred the Petitioner for physical therapy and prescribed Gabapentin. (Px. 5)

The Petitioner testified that prior to his injury he had been using prescription Hydrocodone 7.5 for several years to control pain from an acute infectious colitis that had never cleared up. Records of this illness and prescription are included in Petitioner's Exhibit # 4. Dr. Varney continued the Petitioner's Hydrocodone 7.5 prescription to help alleviate his lower back and leg pain. (Px. 5)

The Petitioner was seen again by Dr. Varney on November 10, 2011. The Petitioner indicated that his pain was not improving. (Px. 5) Dr. Varney noted that Petitioner's physical therapy was not scheduled to begin until the end of December 2011. (Px. 5) Upon physical examination, Dr. Varney noted that the Petitioner had a positive straight leg test on both the left and right sides and that he continued to exhibit pain walking on his toes. (Px. 5) Dr. Varney increased the Petitioner's dosage of Hydrocodone to 10 and took the Petitioner off of work until he could be seen by Dr. Rull. (Px. 5)

The Petitioner was seen by Dr. Rull on November 16, 2011. The Petitioner reported that he was still experiencing the same amount of pain and that his pain was sometimes a 10 out of 10. (Px. 5) He indicated that he could not get comfortable in any position and that the pain was keeping him awake at night. (Px. 5) The Petitioner reported occasional pain radiating down both legs, more so on the right than left, as well as intermittent numbness down the legs. (Px. 5) Dr. Rull examined the Petitioner, noting that he could not get an accurate straight leg test due to the Petitioner's low back pain. (Px. 5) Dr.

Rull prescribed cyclobenzaprine and advised the Petitioner to present to the emergency room if he developed any "red flag symptoms." (Px. 5) Dr. Rull continued the Petitioner's off work restriction until November 30, 2011. (Px. 5)

Dr. Rull followed up with the Petitioner over the telephone on November 17, 2011. (Px. 5) The Petitioner indicated that the cyclobenzaprine helped him sleep, but that he was still in severe pain and was not able to do much at all. (Px. 5) As a result of this conversation, Dr. Rull ordered an MRI of the Petitioner's lumbar spine. (Px. 5)

The MRI was taken on November 18, 2011. The MRI Report was entered into evidence as Petitioner's Exhibit # 7. The MRI showed some moderately severe spinal stenosis at the L3-L4 level secondary to disc bulge with possible focal disc herniation as well as flava hypertrophy degenerative change. (Px. 7) It also showed a moderate spinal stenosis at L2-L3 and edema in the L3 and L4 vertebral bodies that may have represented microfractures. It also showed diffuse disc bulge at the L4-5 level with bilateral neural foraminal deformation with the left being slightly more stenosed than the right. Finally, there is disc bulge at L5-S1 with no spinal stenosis. (Px. 7)

Based on the Petitioner's MRI results and symptoms, Dr. Rull recommended the Petitioner be admitted to Memorial Medical Center for pain control and consultation with a spine surgeon. (Px. 5) The Petitioner ultimately presented to Memorial Medical Center on November 19, 2011. The Memorial Medical Records for November 19, 2011 were entered into evidence as Petitioner's Exhibit # 8. Petitioner was given several injections of hydromorphone for his pain. (Px. 8)

While the Petitioner was at Memorial Medical Center, Mark Eilers, a resident working under orthopedic surgeon Dr. Per Freitag, was called for a consult. (Px. 8) The Petitioner reported that he had injured his back at work on October 31, 2011, while trying to lift up a carton of printer paper. (Px. 8) He reported that he immediately noticed pain in his back and the pain had been unrelenting since. (Px. 8) Upon physical examination, Resident Eilers noted that the Petitioner's back was tender to palpation on the paraspinal musculature and lumbar region, greater on the right than the left. (Px. 8) He also noted markedly diminished patellar reflexes on the right side. (Px. 8)

Resident Eilers reviewed the Petitioner's November 18, 2011 MRI, noting that he had what appeared to be an acute disk bulge at the level of L3-L4 with significant narrowing of the canal. (Px. 8) He also noted a significant amount of increased signal changes at the disk levels of L3-L4, suggestive of an acute injury. (Px. 8)

Resident Eilers diagnosed the Petitioner with an acute ruptured disc at L3-L4 with decreased canal space and foraminal stenosis. (Px. 8) He prescribed the Petitioner a Medrol Dosepak and instructed him to keep his physical therapy appointment for the following Monday, with direction to ensure that the physical therapist was doing McKinzie exercises as other physical therapy could be detrimental. (Px. 8) The Petitioner was subsequently discharged later on November 19, 2011.

The Petitioner returned the Emergency Department at Memorial Medical Center on November 26, 2011. The records from the Petitioner's November 26, 2011 visit to Memorial Medical Center were entered into evidence as Petitioner's Exhibit # 9. The Petitioner testified that he returned to the Emergency Department on that date because his foot was beginning to drop, and he believed that was a sign that his condition was worsening. The treating physician's notes indicated that the Petitioner complained of stiffness in the neck and a warm sensation traveling up the spine. (Px. 9) The Petitioner was evaluated and no imminent problems were

discovered. (Px. 9) Therefore, the Petitioner was instructed to follow up with Dr. Rull within one to two days and was discharged. (Px. 9)

The Petitioner followed up with Dr. Rull on November 29, 2011. The Petitioner reported that since his discharge from Memorial Medical Center on November 26, he had experienced three episodes of right foot drop which lasted for one or two steps. (Px. 5) He reported that he continued to experience intermittent numbness and tingling in both legs, greater on the right side than the left. (Px. 5) He also complained of some tingling in the right upper buttock region. (Px. 5) Dr. Rull took the Petitioner off of work duty until December 12, 2011 and indicated that his suitability to return to work would be reassessed after he presented to physical therapy and was seen by Dr. Freitag. (Px. 5) The Petitioner continued to follow up with Dr. Rull for management of his pain medication throughout his treatment for his back. Dr. Rull continued to keep the Petitioner on an off work restriction until February 4, 2013. (Px. 5)

The Petitioner first presented to Dr. Freitag on December 8, 2011. Dr. Freitag's records were entered into evidence as Petitioner's Exhibit # 6. Dr. Freitag also testified via his evidence deposition, taken on December 3, 2012, which was entered into evidence as Petitioner's Exhibit # 21. Dr. Freitag testified that he is an orthopedic surgeon and that he primarily performs spine surgery. (Px. 21, p. 6) Dr. Freitag is also an Associate Professor of Orthopaedic Surgery at Southern Illinois University School of Medicine. (Px. 21, p. 8)

On his first visit to Dr. Frietag, the Petitioner reported that he had a work accident where he attempted to pick up a box of paper and experienced instant back pain that had continued and extended into the legs. (Px. 6) He reported that his pain was worse when he was sitting or with any level of activity or bending and that it was better when he was lying flat. (Px. 6) He also reported that over the previous several weeks he had experience a couple episodes where his right foot dropped, meaning he was unable to keep it dorsiflexed while walking. (Px. 6)

On physical examination, Dr. Freitag noted bilateral weakness of the extensor halluces longus, tibialis anterior, and gastroc-soleus complex, worse on the right than the left. (Px. 6) He noted that the weakness was most significant on the right lower extremity, extensor halluces longus, and sibialis anterior. (Px. 6) He opined that the locations of most significant weakness indicated L4-L5 nerve root involvement. (Px. 6) Dr. Freitag testified that the Petitioner also exhibited a positive bilateral straight leg test, which he testified means that the Petitioner had increased pain in the legs when they were lifted. (Px. 21, pp. 15-16)

Dr. Freitag ordered x-rays of the lumbar spine, which were taken and reviewed in office the same day. The x-ray report was entered into evidence as Petitioner's Exhibit # 10. The x-ray showed disc space narrowing at all levels between L2-S1, most significantly at the L3-L4 interspace. (Px. 10) It also showed some evidence of retrolisthesis of L5 on S1. (Px. 6) Dr. Freitag also reviewed the Petitioner's November 18, 2011 MRI films. (Px. 10) He testified that the MRI revealed some stenosis at L 3-4 with a disc herniation or protrusion and some hypertrophy or thickening of the ligamentum flavum. (Px. 21, p. 16) The MRI also showed some bulging of the disc at L4-5 and L5-S1. (Px. 21, p. 17)

Dr. Freitag acknowledged that the Petitioner's MRI report indicated a focal disc herniation at L3-4, however he testified that this was not consistent with the Petitioner's presentation on December 8, 2011, because herniation at L3-4 would not involve the L5 nerve root. (Px. 21, p. 17) Dr. Freitag also testified that while the narrowing and stenosis indicated on the MRI was degenerative in nature, the disc protrusion was obviously related to a trauma because it was focal. (Px. 21, p. 17) Furthermore, Dr. Freitag indicated that although the degenerative findings predated the Petitioner's October 31, 2011 date of accident, his review of the Petitioner's medical records indicated that the degenerative findings had been asymptomatic for quite some time

prior to that date. (Px. 21, pp. 17-18) He also opined that the disc bulging at L3-4 could have an acute cause because it was central and more towards the right side. (Px. 21, p. 18)

Dr. Freitag recommended that the Petitioner continue with physical therapy. (Px. 6) He testified that the continued physical therapy was reasonable and necessary within a reasonable degree of medical certainty because generally in bulging disc cases, good physical therapy can resolve the issue. (Px. 21, p. 19) He also recommended an EMG study in order to help localize which nerve root was most affected. (Px. 6) Dr. Freitag testified that an EMG is more accurate than an MRI when it comes to predicting the outcome of improvement from treatment because it shows the specific nerve root involved. (Px. 21, p. 19) Dr. Freitag planned to perform a transforaminal injection if the EMG results showed pathology at a specific nerve root. (Px. 6)

The Petitioner presented to Physio Therapy Professionals for physical therapy on January 20, 2012. The Petitioner's records from Physio Therapy were entered into evidence as Petitioner's Exhibit # 11. He continued to treat with Physio Therapy Professionals until February 17, 2012, at which time he was discharged. (Px. 11) The Petitioner's visit notes from January 26, 2012, January 30, 2012, and February 1, 2012 indicated that the Petitioner had difficulty with all of the exercises due to pain, but that he managed to work through them. (Px. 11)

On March 12, 2012, the Petitioner underwent an EMG with Dr. Zen Wang at SIU HealthCare. The EMG report was entered into evidence as Petitioner's Exhibit # 12. Dr. Wang noted on physical examination that the Petitioner had slightly decreased sensation to his feet and that he exhibited bilateral lumbosacral radiculopathy and peripheral neuropathy in the lower extremities. (Px. 12) After reviewing the EMG studies, Dr. Wang concluded that the Petitioner had bilateral moderate lumbosacral radiculopathy of the nerve roots of L4, L5 and S1, with L5 predominant involvement, as well as some likely diabetic mild sensory neuropathy bilaterally. (Px. 12) Dr. Freitag testified in his evidence deposition that the EMG indicated two different sources of nerve involvement. The neuropathy involving the L4, L5, and S1 nerve roots emanated from the spine itself, while the mild sensory neuropathy was likely caused by the Petitioner's diabetes. (Px 21, pp. 20-21) Dr. Freitag further testified that the EMG results were consistent with his clinical examination of the Petitioner, especially the L5 nerve root involvement because of the Petitioner's weakness in his big toe extensor. (Px. 21, p. 21)

The Petitioner returned to Dr. Freitag's office on March 21, 2012 for follow up regarding his EMG results. He indicated that he was unable to do significant walking or standing secondary to his severe back pain. (Px. 6) Dr. Freitag indicated that the EMG results showed bilateral L4-L5 and L5-S1 radiculopathy. (Px. 6) The Petitioner complained that his pain was worse on the right side than the left, and that he was experiencing pain all the way down from his hip to his leg. (Px. 6) Upon physical examination, Dr. Freitag noted that the Petitioner had some tenderness along the lumbar spine which was moderate to severe for the patient. (Px. 6) Dr. Freitag recommended a right L5 transforaminal lumbar epidural steroid injection. (Px. 6) He testified that the epidural steroid injection was reasonable and necessary treatment because the EMG indicated primary L5 radiculopathy, which indicated treatment of that nerve root in particular (Px. 21, p. 24) Dr. Freitag placed the Petitioner under an off work restriction until further notice. (Px. 6)

The Petitioner presented to Dr. Ferdinand Salvacion of Spineworks Pain Center for consultation for a transforaminal lumbar epidural steroid injection on April 17, 2012. Dr. Salvacion's records were entered into evidence as Petitioner's Exhibit # 13. Upon physical examination, Dr. Salvacion noted that the Petitioner's gait was stiff and that his lumbar range of motion was limited in flexion and extension secondary to pain. (Px. 13) He noted that he had a positive straight leg raise on the right leg. (Px. 13) Dr. Salvacion also reviewed the Petitioner's MRI of the lumbar spine and EMG results. (Px. 13) Dr. Salvacion diagnosed the Petitioner with

lumbar stenosis, lumbosacral radiculopathy, and lumbar degenerative disc disease. (Px. 13) Dr. Salvacion scheduled the Petitioner for a trial lumbar epidural steroid injection. (Px. 13)

The Petitioner underwent the first of a series of epidural steroid injections on May 8, 2012 with Dr. Salvacion. The records from the epidural steroid injection were entered into evidence as Petitioner's Exhibit # 14. The Petitioner testified that subsequent to the injection, he became quite ill. He indicated that he woke up at 3:30 in the morning after the injection, was vomiting, had a splitting headache, and was in intense pain. He testified that he presented to Memorial Medical Center for treatment, but was instructed to present to St. John's Hospital because the emergency room was closed. He testified that he ultimately followed up at St. John's Hospital. The St. John's Hospital records from May 9, 2012 were entered into evidence as Petitioner's Exhibit # 26.

Dr. Freitag indicated that there were two possible causes for the Petitioner's adverse reaction to the epidural steroid injection. First, he testified that epidural steroid injections often cause a significant rise in blood sugar in diabetic patients, up to 600 or 700. (Px. 21, p. 25) Dr. Freitag indicated that the Petitioner's severe headaches, nausea, vomiting, and ultimate state of being bedridden were indicative of high blood sugar. (Px. 21, p. 25) Second, Dr. Freitag testified that there could have been an incidental penetration of the dura causing a dura leak, which can cause a spinal headache involving nausea. (Px. 21, pp. 25-26)

On May 30, 2012, the Petitioner returned to Dr. Freitag's office. Dr. Freitag testified that the Petitioner exhibited no improvement from the epidural steroid injection and that he still had lumbosacral radiculopathy. (Px. 21, p. 26) Dr. Freitag recommended that the Petitioner undergo a foraminal decompression to his lumbar spine. (Px. 6) Dr. Freitag testified that he opted for a decompression only opposed to a decompression and fusion because of the possible negative future side effects fusion could have on the Petitioner's bulging disc at L3-4. (Px. 21, pp. 26-27) Further, Dr. Freitag testified that the decompression would help with the radiculopathy, which would help with the back pain some and resolve the pain to the legs. (Px. 21, p. 27) Dr. Freitag testified that although fusion was an option, the long term side effects did not make it the best option. (PX. 21, p. 28) Dr. Freitag continued the Petitioner's off duty restriction pending surgery. (Px. 6)

On September 19, 2012, the Petitioner returned to Dr. Freitag. (Px. 6) He indicated that his pain was progressively getting worse. (Px. 6) Dr. Freitag noted on physical examination that the Petitioner exhibited bilateral positive straight leg test with definite weakness of both big toe extensors. (Px. 6) At this time, Dr. Freitag scheduled the Petitioner for foraminal decompression surgery. (Px. 6) Dr. Freitag extended the Petitioner's off work restriction until after February 2, 2012, to allow for recovery from surgery.

The Petitioner underwent two level foraminal decompression surgery on November 2, 2012 with Dr. Freitag. Prior to surgery, the Petitioner was required to undergo a number of tests in order to be cleared for surgery. The records of these tests, taken at Memorial Medical Center, were entered into evidence as Petitioner's Exhibit # 17. He further was required to receive cardiac clearance for the surgery which was given by Dr. Wilfred Lam. Dr. Lam's records were entered into evidence as Petitioner's Exhibit # 16.

Dr. Freitag's operative report was entered into evidence as Petitioner's Exhibit # 18. Dr. Freitag testified that he performed a lumbar decompression at L4-5 and L5-S1, which involved taking down the facet joints and opening up the foramina and decompressing the nerve at those two levels. (Px. 21, p. 30) Dr. Freitag's post-operative diagnoses were marked foraminal stenosis at L4-L5 and L5-S1 bilaterally, with more pain on the right and neuralgia of the sciatic nerve. (Px. 18) He testified that in his opinion the decompression surgery was reasonable and necessary treatment for the Petitioner because conservative treatment had failed and his condition was becoming worse. (Px. 21, p. 30)

As a result of catheterization during surgery, the Petitioner developed urinary retention, which necessitated the intervention of Dr. Alex Gorbonos, a urologist. Dr. Gorbonos' records were entered into evidence as Petitioner's Exhibit # 20. This issue has since resolved. Furthermore, as a result of this complication, the Petitioner was required to be hospitalized at Memorial Medical Center for five days opposed to one day.

The Petitioner returned to Dr. Freitag's office on November 14, 2012 for a post-operative follow up. (Px. 6) He reported that his pain had decreased since the surgery. (Px. 6) Dr. Freitag testified that the Petitioner looked like he was doing somewhat better and was no longer experiencing pain in his legs. (Px. 21, p. 32) He testified that the surgery seemed successful at that point. (Px. 21, p. 32) Upon physical examination, Dr. Freitag noted no discomfort to the lumbar spine with palpation and a negative straight leg test on both sides. (Px. 6) Dr. Freitag referred the Petitioner for hydrotherapy and ordered Percocet for pain. (Px. 6) The Petitioner presented for hydrotherapy at the YMCA on November 28, 2012. The YMCA Physical Therapy Records were entered into evidence as Petitioner's Exhibit # 25. The Petitioner continues to receive hydrotherapy at the YMCA. (Px. 25)

On December 18, 2012, the Petitioner was terminated from his position with the Respondent. The Petitioner's termination letter was entered into evidence as Petitioner's Exhibit # 28. The reason given for the Petitioner's termination was his extended absence from work while treating for his injury. (Px. 28)

On February 4, 2013, the Petitioner was seen by Jacob Monsivais, a Physician's Assistant in Dr. Rull's office. The notes from this office visit were entered into evidence as Petitioner's Exhibit # 29. At that time, P.A. Monsivais returned the Petitioner to work with a light duty restriction of no lifting greater than 50 pounds and no repetitive bending and twisting activities. (Px. 29) This was the last return to work slip the Petitioner received prior to the February 7, 2013 Arbitration Hearing.

In his evidence deposition, Dr. Freitag testified that his ultimate diagnosis of the Petitioner was foraminal compromise because of neuropathy and radiculopathy due to the twisting while he was holding a box of printer paper at work. (Px. 21, p. 34) He testified that although the Petitioner had some preexisting degenerative changes in his back prior to the work injury, they had been asymptomatic and that these degenerative changes had been exacerbated by the injury. (Px. 21, p. 34)

The Petitioner was sent for an Independent Medical Evaluation (IME) with Dr. David Lange, an orthopedic spine surgeon. Dr. Lange testified via his evidence deposition, entered into evidence as Respondent's Exhibit # 3. Dr. Lange testified that the Petitioner reported to him that he had been injured on October 31, 2011 while picking up a box of paper, that he noticed something was wrong with his back, and that he immediately dropped the box. (Rx. 3, p. 8) It was Dr. Lange's opinion that the Petitioner suffered from mechanical low back pain due to degenerative changes in his back and that his symptoms to the lower extremities could be due to spinal stenosis or peripheral neuropathy. (Rx. 3, p. 21)

Dr. Lange further testified, that his notes from taking the Petitioner's history said " "went to pick up a box of paper." I dropped it to the floor. "60 to 70 pounds." As soon as I turned, I knew something was wrong." He indicated that his notes did not indicate when the box was dropped, and in fact did not even suggest that he dropped the box. (Rx. 3, p. 35) Dr. Lange testified that if the Petitioner had not immediately dropped the box, it might affect his opinions with regards to the Petitioner's injury. (Rx. 3, p. 36) Dr. Lange testified that neither the Report of Injury nor Supervisor's Investigation Report indicated that the Petitioner immediately dropped the

box. (Rx. 3, p. 39) Dr. Lange further testified that stills of the surveillance video were consistent with the Petitioner picking up the box and turning with it. (Rx. 3, p. 40-41)

Dr. Lange further testified that on one of the stills, it looked like the Petitioner was grabbing his lower back and that such an action would be consistent with having sustained a sprain-strain or other type of injury to the lower back. (Rx. 3, p. 42) Dr. Lange then testified if the Petitioner had twisted his back while working with the box enough that he dropped the box, than the Petitioner may have sustained a sprain-strain or other low back injury on October 31, 2011. (Rx. 3, pp. 43-44)

Dr. Lange also testified that he did not see any medical record regarding back issues in the Petitioner's medical records from 2007 up until the date of accident. (Rx. 3, p. 46) While Dr. Lange opined that he Petitioner had degenerative findings in his lower back prior to October 31, 2011, he testified that a person can have degenerative disc findings like the Petitioner's and not have symptoms. (Rx. 3, p. 47) Further, he testified that lifting a box weighing 50 to 60 pounds and then twisting could cause an exacerbation of an underlying degenerative disc disease and caused it to become symptomatic. (Rx. 3, p. 47) He also testified that considering the Petitioner's medical records were devoid of any complaints of lower back pain from 2007 until October 31, 2011, and that Petitioner had complaints almost immediately following his trauma on October 31, 2011, it would be "illogical to disagree with" the contention that he sustained an aggravation or exacerbation of his underlying degenerative disc disease which caused him to be symptomatic. (Rx. 3, pp. 55-56)

Dr. Lange testified that the Petitioner's EMG findings of bilateral moderate lumbosacral radiculopathy of the nerve roots of L4, L5, and S1, with L5 being the predominant involvement were objective findings and would explain the complaints that the Petitioner presented with regard to his legs. (Rx. 3, pp. 53-54)

The Petitioner testified that subsequent to his surgery, he no longer has radicular symptoms and that his back pain has improved. He testified that he would like to return to work, and has been working on his resume in order to find new employment.

After a review of the totality of the evidence, the Arbitrator finds that on October 31, 2011, the Petitioner sustained an accident arising out of and in the course of his employment with the Respondent when he lifted a box of paper and twisted, causing immediate discomfort to his back. The photographs from the Respondent's security camera included in Respondent's Exhibit # 3 clearly show that the Petitioner picked up a box of paper and subsequently twisted on the date and time reported. Furthermore, these photographs also show the Petitioner pushing on his lower back in apparent distress and discomfort. (Rx. 3, PDEx. 3)

While the Petitioner admitted not reporting his accident on the date it happened, the circumstances do not cause the Arbitrator to change his conclusions on accident. Mr. Short, who was the only other person who was in the Petitioner's work area after he had lifted the box, testified that he saw the Petitioner lifting the box and did not notice anything unusual about his posture or facial expression. He admitted, however, that he was doing his own work and only observed the Petitioner for a couple of seconds. The Petitioner, whose work day ended about twenty minutes after his accident, said that at that time he was only experiencing back pain and that his legs began to bother him over the next two days. He also reported his accident to his manager, Ms. Cook, the following day.

Relying primarily on the testimony and medical records of the Dr. Freitag and the medical records of Dr. Rull, both prior to and subsequent to the date of accident, the Arbitrator finds that the Petitioner's lower back and leg pain was causally connected the October 31, 2011 work accident. Although the Petitioner had by his own admission treated for lower back pain in the past, Dr. Rull's pre-accident records indicate that the

Petitioner had not complained of any back pain for the four years prior to the accident. (Px. 4) Furthermore, Dr. Freitag testified that the Petitioner had suffered foraminal compromise because of neuropathy and radiculopathy caused by the accident. (Px. 21, p. 34) He opined that the Petitioner's disc bulging at L3-4 could have an acute cause because it was central and more towards the right side. (Px. 21, p. 19) He also testified that the Petitioner's pre-existing degenerative changes were aggravated and exacerbated by the injury. (Px. 21, p. 34) Therefore, the Arbitrator finds that the Petitioner sustained an accidental injury on October 31, 2011 when he picked up and twisted his body while holding a box of paper weighing fifty to sixty pounds and his condition of ill-being is causally related to his October 31, 2011 work accident.

In support of the Arbitrator's decision relating to issue (J), Medical Expenses, the Arbitrator finds the following facts:

Dr. Freitag has testified that the Petitioner's physical therapy, epidural steroid injection, and decompression surgery were all reasonable and necessary treatment for the Petitioner's lower back and leg complaints. (Px. 21, pp. 19, 24, 30) Therefore, the Arbitrator finds that all of the Petitioner's treatment was reasonable and necessary for treatment for his work related injuries.

The Respondent shall pay the outstanding medical bills, as set forth in Petitioner's Exhibit # 24 directly to the medical providers pursuant to the Medical Fee Schedule set forth in Section 8(a) of the Act. Respondent shall be given a credit pursuant to Section 8(j) in the amount of $14,620.65 for all bills paid by Blue Cross/Blue Shield and will hold Petitioner harmless for any subrogation claim asserted by Blue Cross/Blue Shield. Specifically, the Respondent shall settle the Liens of Blue Cross/Blue Shield set forth in Petitioner's Exhibits # 22 and # 23.

The Arbitrator further orders the Respondent to reimburse the Petitioner in the amount of $582.26 for out-of-pocket medical expenses paid by the Petitioner for injuries arising from the accident of October 31, 2011.

In support of issue (K), Temporary Total Disability, the Arbitrator finds the following facts:

The Petitioner missed work on November 3 and 4, 2011 in order to attend doctor's visits and to manage his pain shortly after the accident. He was then excused from work by Dr. Varney, Dr. Rull, and Dr. Freitag from November 11, 2011 until February 4, 2013. On February 4, 2013, the Petitioner was returned to work by Dr. Rull's physician's assistant with a light duty restriction of no lifting greater than 50 pounds and no repetitive bending and twisting. (Px. 29) The Petitioner was terminated from his position with the Respondent on December 18, 2012. (Px. 28) Prior to the Arbitration hearing on February 7, 2013, the Petitioner had not returned to work anywhere.

The Arbitrator awards the sum of $289.69 per week for 65 and 1/7 weeks for the time period of November 3, 2011 through November 4, 2011 and the time period of November 11, 2011 through February 7, 2013. The Respondent shall be given a credit in the amount of $15,446.36 representing Temporary Total Disability benefits the Respondent has already paid to the Petitioner.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
JEFFERSON

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kevin Garrett,
Petitioner,

vs.

NO: 11WC 46777

Transport Labor Contract/Delco Transport,
Respondent,

14IWCC0226

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, causal connection, medical expenses, prospective medical treatment, notice and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 29, 2013, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 8 2014
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RWW/jrc
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR

GARRETT, KEVIN
Employee/Petitioner

Case# **11WC046777**

14IWCC0226

TRANSPORT LABOR CONTRACT/DELCO TRANSPORT
Employer/Respondent

On 8/29/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0465 SCHEELE CORNELIUS & HARRISON PC
DAVID C HARRISON
7223 S ROUTE 83 PMB 228
WILLOWBROOK, IL 60527

1826 LEAHY EISENBERG & FRAENKEL LTD
JAMES P TOOMEY
33 W MONROE ST SUITE 1100
CHICAGO, IL 60603

STATE OF ILLINOIS)SS.

COUNTY OF Jefferson)

14IWCC0226

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Kevin Garrett
Employee/Petitioner

v.

Transport Labor Contract/Delco Transport
Employer/Respondent

Case # 11 WC 46777

Consolidated cases: ___

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **07-09-2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other ___

14IWCC0226

FINDINGS

On the date of accident, **02-18-2011**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did not* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was not* given to Respondent.

Petitioner's current condition of ill-being *is not* causally related to the accident.

In the year preceding the injury, Petitioner earned $**1,893.94**; the average weekly wage was $**473.49**.

On the date of accident, Petitioner was **38** years of age, *married* with **2** dependent children.

Respondent *has not* paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**2,000.00** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

Respondent is entitled to a credit of $**0** under Section 8(j) of the Act.

ORDER

Petitioner failed to meet his burden of proof regarding the issue of accident. Claim denied.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

8/22/13
Date

ICArbDec19(b)

AUG 29 2013

FINDINGS OF FACT

Testimony of Petitioner, Kevin Garrett

Petitioner, who was 5'11" tall and weighed 368 pounds as of the date of hearing, testified that he was employed as a diesel mechanic by Respondents, Transport Labor Contract and Dellco Transport (hereafter Respondent) on February 18, 2011. He classified the work as "heavy" work, which would include lifting 100 pounds. Petitioner agreed that he began working for Respondent on January 21, 2011. Petitioner testified that in October of 2010, he had settled two workers' compensation claims for injuries related to his left knee, case numbers 10 WC 1396 (date of accident October 9, 2009) and 10 WC 18727 (date of accident of April 4, 2010). Petitioner identified Pet. Ex. 3 as the settlement contract and indicated that he signed the document. The Arbitrator notes that these claims against Travel Center of America resolved for approximately 45.1% loss of use of the left leg.

Petitioner testified that prior to February 18, 2011, he was able to perform his full duties with Respondent. He testified that he had "a little" problems with his left knee. On the date of accident, he was under a semi-trailer attempting to break free frozen brakes with a hammer. He testified that three other individuals were present at the occurrence site: Brian Moran, who was driving the semi-tractor; Patrick Guenther; and Troy Slifer. While he was under the trailer, Patrick Guenther told Brian Moran to pull forward. Petitioner testified that his left knee became pinned between the ICC bumper of the trailer and the pavement. He testified that the ICC bumper "rolled" over his leg. After becoming pinned between the ICC bumper and the pavement, his left knee became hard to bend and became swollen. He testified that his knee brace was broken, and that he told Mr. Moran and Mr. Guenther about the incident. Petitioner testified that Mr. Moran requested that he not seek medical attention, as Mr. Guenther was currently treating for a workers' compensation injury.

Petitioner continued working for Respondent and his left knee condition worsened. He wore a bandage, and his knee swelled up daily. He testified that he told Mr. Moran of his worsening left knee condition. Petitioner's last date of work with Respondent was March 17, 2011, when he was laid off. Thereafter, he received unemployment insurance benefits. He has applied for approximately 50 jobs in the past six months, including fast food restaurants, as he likes to work.

Petitioner saw Dr. Robert Gurtler, the orthopedic surgeon who performed his prior left knee surgery, on July 27, 2012. He indicated that Dr. Gurtler administered a cortisone injection that helped for 2 weeks, but that his knee problems returned.

Petitioner testified that his left knee continues to bother him. He testified that he utilizes a cane, as if he does not use his cane, he "falls on [his] face." He can walk approximately a block without his cane. He testified that he elevates his leg while sitting, and that he has to move his leg if he sits for more than 5-10 minutes. Petitioner testified that he could stand for five to six minutes, but then needs to lean or sit down. He additionally indicated that he climbs stairs one at a time, using his right leg to step first. He also indicated that his left knee pops, and that he wakes up three to four times a night due to left knee pain.

On cross-examination, Petitioner testified that he was working on the trailer driver side brake, and that his entire body was under the trailer. He testified that Mr. Guenther was operating as a spotter for Mr. Moran on the driver side of the trailer, and that Mr. Slifer was on the passenger side of the trailer. Petitioner admitted that he did not seek medical treatment at any time through September 2011, when he first made a claim through Respondent's insurance carrier. He testified that he had filed a previous workers' compensation claim for his

left knee, and a claim for his right knee many years ago. In fact, the present matter is Petitioner's ninth workers' compensation claim filed with the IWCC, ranging from accidents in 1999 through 2011.

Petitioner additionally testified that he understood he closed out any future medical benefits for his left knee when he settled the two claims against Travel Center of America for his left knee injuries on October 9, 2009 and on May 4, 2010. He indicated that he did not work between the time he settled his claims against Travel Center of America and the start of his employment with Respondent. He additionally testified that he had no group medical insurance from the time he settled his claims with Travel Center of America and throughout his employment with Respondent. He admitted that he was terminated by Travel Center of America because his supervisor was not accommodating his restrictions.

Petitioner testified that he advised Brian Moran of his permanent restrictions when he was hired by Respondent, and that he adhered to his restrictions. He admitted that Dr. Gurtler provided him no off work note on his visit on July 26, 2012. He agreed that during that visit, Dr. Gurtler advised that he was not a candidate for a left knee replacement, and that he needed to lose 50 pounds. This was similar to the previous visit on September 7, 2010. Petitioner agreed that on his first visit with Dr. Gurtler on January 7, 2010, he weighed 335 pounds, but that on July 26, 2012, he weighed 387 pounds. He admitted that he had a one pack per day cigarette smoking history for 14 years. Petitioner agreed that on his July 26, 2012 visit, he told Dr. Gurtler he had been doing "well" until a year prior. Petitioner was then questioned regarding his visit on September 7, 2010. He admitted to instability in the knee, but claimed the only pain he experienced was from his brace.

Petitioner admitted that he has a physician who prescribes his blood medication, Dr. Zahoor, and that he has seen the doctor as recently as a month ago. Petitioner denied ever telling Dr. Zahoor about his knee complaints or seeking treatment from Dr. Zahoor.

Testimony of Troy Slifer

Petitioner called Troy Slifer as an occurrence witness. Mr. Slifer testified that on February 18, 2011, he was a part-time employee of Respondent. He testified that on the date of accident, there were two trailers side by side in the trailer drop yard. He testified that he fixed the brakes on one trailer, and that Petitioner fixed the brakes on the other trailer. According to Mr. Slifer, Petitioner, Mr. Guenther, Mr. Moran, and himself were present at the scene. He testified that Mr. Guenther yelled for the trailer to move, and that he noticed Petitioner under the trailer. Mr. Slifer testified that he yelled to Mr. Moran to stop the trailer, but it was too late: Petitioner was struck by the ICC bumper. Mr. Slifer testified that Petitioner got out from under the trailer and was limping on the leg that he had previously injured. Mr. Slifer testified that Mr. Moran was concerned that he would have to take Petitioner to the hospital, and that he advised Petitioner to attempt to "walk it off." On cross-examination, Mr. Slifer admitted that he was 20-30 feet away from Petitioner and Mr. Moran after the alleged incident and could not hear the conversation. He testified that Petitioner never made any left knee complaints while working for Respondent prior to the February 18, 2011 incident. He admitted that Petitioner did walk slowly with a limp. He testified that he currently works for Travel Center of America, where Petitioner previously injured his left leg. Mr. Slifer further testified that he considers himself a personal friend of Petitioner, and has known Petitioner for nine years. In fact, he testified that he currently lives with Petitioner, and he gave a recorded statement to Phil Liotta at Petitioner's residence. He testified that he has never discussed the details of Petitioner's accident with Petitioner since February 18, 2011.

Respondent's counsel presented Mr. Slifer with Respondent's Ex. 2, which Mr. Slifer indicated he signed and filled out. Respondent's Ex. 2 is a "Witness Report" dated September 27, 2011 that Mr. Slifer indicated he received from the workers' compensation carrier. Mr. Slifer read his description of the accident on Resp. Ex. 2: "they were backing up trailer into garage boss Brain [*sic*] Marion [*sic*] got trailer to [*sic*] close to building while backing up." Resp. Ex. 2. Mr. Slifer further read "that they smashed or got Kevins knee caught between building & ICC bumper while backing trailer in shop." When asked to explain the obvious difference between the "witness report" history and his testimony under oath, Mr. Slifer indicated, after obvious stammering, that his "witness report" was for a second accident that occurred involving Petitioner's left knee. He stated that the "witness report" was for a "totally different deal here," as it occurred at the shop, not at the trailer drop site.

Testimony of Patrick Guenther

Petitioner then called Patrick Guenther as a witness. Mr. Guenther testified that he was employed as a driver / mechanic with Respondent for a couple years, but that he is currently unemployed. On February 18, 2011, he was at the truck parking lot at Fleetmaster because brakes had frozen on a trailer. According to Mr. Guenther, no other trailers were being worked on at the same time. He was hurt at the time and was wearing a sling, so he could not crawl underneath the trailer. He explained that Petitioner crawled underneath the trailer to attempt to free the frozen brakes, and that Petitioner hollered for the trailer to move forward. When Petitioner yelled stop, Mr. Guenther yelled stop to Mr. Moran. Mr. Guenther testified that he did not actually see an accident occur, but that Petitioner came out from under the trailer and stated "man that hurt," and that Petitioner further told him that he bumped his knee. He observed Petitioner limping. Mr. Guenther testified that Mr. Moran walked back toward Petitioner and himself, but he did not know if Mr. Moran was aware of any incident. He admitted that Mr. Moran was his brother-in-law, and that he and Mr. Moran rode to the hearing site together.

On cross-examination, Mr. Guenther testified that while he was wearing a sling, he had other job duties to do, including making telephone calls. Mr. Guenther testified that Troy Slifer was not present when the incident occurred. Mr. Guenther testified that he received a pay check for his work on February 18, 2011. He testified that Petitioner did not really make complaints related to his left leg before the incident, but Petitioner had informed him that he hurt his leg before at Travel Center of America. Mr. Guenther agreed that his last day of work for Respondent was about March 30, 2011, when the company closed. He had not discussed the details of the incident with his brother-in-law, Mr. Moran. After Petitioner got out from under the trailer, Mr. Guenther asked if Petitioner was okay. Petitioner replied that he was hurting but he thought he was okay. Mr. Guenther testified that Petitioner did make left knee complaints after February 18, 2011, and had to "sit down for a bit" on occasion. Mr. Guenther testified that he "kinda sorta" ran the shop, but that his job duties did not include anything related to workers' compensation claims. He testified that he never told Petitioner to avoid seeking medical treatment, and he never reported the incident to Mr. Moran.

Mr. Guenther was presented with Resp. Ex. 3, which was a settlement contract for two claims against "Delco Transport" for injuries sustained on December 15, 2010 (case number 11 WC 13901) and January 20, 2011 (11 WC 12554). Petitioner acknowledged that he signed the contract, which was settled for left arm injuries for 11% loss of use of the left arm and was approved on July 24, 2012. The settlement contract indicates that Mr. Guenther was paid TTD benefits of $437.17 per week for 32 weeks, from February 4, 2011 through September 21, 2011. When asked about the settlement contracts, Mr. Guenther then changed his testimony and indicated that although he was working on the date of occurrence of February 18, 2011, he did not receive a paycheck—he instead was only receiving workers' compensation benefits.

Testimony of Brian Moran

Respondent called Brian Moran as a witness, who testified that he was a driver / manager of Respondent as of February 18, 2011, and was also a "part-owner" of Dellco Transport. He testified that he was unaware of any permanent work restrictions that Petitioner had prior to February 18, 2011. He did not recall Petitioner wearing a protective device. During his employment with Respondent, Mr. Moran indicated that he recalled three other workers' compensations claims. He testified that injured workers would notify their supervisor or Mary Banning, who handled reporting injuries to TLC. The only occurrence he could remember relative to Petitioner was at the Fleetmaster parking lot. He testified that it was daylight and a chilly day, and that Petitioner was helping free frozen brakes on a trailer. Mr. Moran testified that he called Mr. Guenther to release the frozen brake, but Petitioner released the brake because Mr. Guenther was injured. Mr. Moran testified that Petitioner yelled to roll forward, so he pulled forward approximately three feet. He testified that he then drove the truck and parked it. He denied getting out of the truck to speak with Petitioner or Mr. Guenther. Mr. Moran testified that he would not have been able to see any injury occur, as the length of the tractor and trailer was 80 feet. He testified that he had no conversation with Petitioner regarding any injury on that day, and that he did not know about a workers' compensation claim until he spoke with Respondent's attorney. Mr. Moran additionally denied that he ever told Petitioner to refrain from seeking medical treatment. Mr. Moran further testified that he stopped working for Respondent on March 30, 2011, and that he recalled the date because it was the day when Illinois Registration Permits were due and one of the owners was selling off the company. Mr. Moran testified that Petitioner contacted him later in the year to discuss the present claim.

Medical Evidence

Petitioner introduced medical records from Dr. Paul Oltman as Petitioner's Exhibit 1. These records relate to medical treatment for Petitioner's previous October 9, 2009 accident date. Petitioner first sought treatment with Dr. Oltman on October 16, 2009, seven days after the date of accident with Travel Center of America. (PX 1) Petitioner underwent x-rays of the left knee on December 14, 2009 at St. Anthony's Memorial Hospital, which showed nonspecific mild degenerative changes with marginal osteophytes arising from the lateral femoral condyle and tibial plateau. (PX 1) Petitioner underwent an MRI of the left knee on December 17, 2009, which showed a complex multidirectional tear of the body and posterior horn of the lateral meniscus; a horizontal oblique tear of the posterior horn of the medial meniscus that extended to the inferior articular surface; mild tricompartmental osteoarthritis with chondrosis; a small joint effusion with a tiny popliteal cyst; and a small probable ganglion cyst anterior to the proximal tibiofibular joint. (PX 1)

Petitioner then came under the care of Dr. Robert A. Gurtler, an orthopedic surgeon. On January 7, 2010, Dr. Gurtler reviewed the MRI of the left knee and agreed with the radiologist's findings, noting arthritis in addition to the tears. Dr. Gurtler recommended surgery but advised that he cannot change the fact that Petitioner has arthritis in his knee, and noted that Petitioner weighed 335 pounds. (PX 2) On February 8, 2010, Dr. Gurtler performed arthroscopic surgery on Petitioner's left knee at Carle Surgicenter. Dr. Gurtler noted that that he performed "basically" a total meniscectomy of the medial meniscus. He then performed a total lateral meniscectomy due to complete disruption of the lateral meniscus. (PX 2)

Petitioner's last treatment with Dr. Gurtler's office prior to the February 18, 2011 occurrence was on September 7, 2010, wherein it was noted that Petitioner had a continued struggle with instability and pain. Petitioner noted that his left knee occasionally felt as if it was going to give out. After reviewing the x-rays, Dr. Gurtler agreed

that the restrictions of wearing a brace, eight hour shifts, and no kneeling or squatting would be permanent. The medical records indicated, "At some point in time in the future, he will need a knee replacement, but he is too young at this juncture." (PX 2) Petitioner did not wish to undergo the viscous supplementation injections recommended. (PX 2)

Petitioner next saw Dr. Gurtler on July 26, 2012, complaining of pain and swelling for a year after his left knee was caught under a trailer and twisted, damaging his brace. (PX 4). Petitioner told Dr. Gurtler that he was doing "well" until this incident. Dr. Gurtler noted that Petitioner weighed 387 pounds with a BMI of 55. Dr. Gurtler reviewed the MRI from March of 2012 and noted no new meniscal damage but severe osteoarthritis, particularly in the medial compartment. X-rays showed a little bit of joint space narrowing and a little bit of varus deformity, but no profound osteoarthritis. Dr. Gurtler administered a cortisone injection, and noted that his weight was a "big factor" in his pain. Dr. Gurtler opined that no arthroscopic surgery would help, and that he would need a total knee replacement "undoubtedly someday," but that he would need his BMI to be below 50. (PX 4) Petitioner's x-ray report from July 26, 2012 noted scattered degenerative spurring and mild medial compartment and patellofemoral narrowing, and that there was "[n]o change from 2010." (PX 4)

Dr. Gurtler testified via evidence deposition on March 12, 2013. He testified that the injury as described from 2011 could have made Petitioner's arthritis worse. Dr. Gurtler testified on cross-examination it was fair to state that the need for a knee replacement had nothing to do with the alleged twisting accident of February 18, 2011. (PX 6, p. 10, 27) He further testified that he could not differentiate whether the worsening of Petitioner's osteoarthritis was due to weight, smoking, or the accident. Dr. Gurtler agreed that Petitioner's weight had a deleterious effect on his knees, and such weight would accelerate an osteoarthritic condition even without a knee injury. (PX 6, p. 17) Dr. Gurtler indicated that he did not recall Petitioner requesting a new knee brace. He admitted that there was no appreciation of swelling of the left knee on July 16, 2012. (PX 6, p. 17-18) Dr. Gurtler further conceded that based upon a review of Petitioner's medical treatment records through September 7, 2010, it was fair to state that Petitioner was not doing "well" upon his release. (PX 6, p. 25)

On February 6, 2012, Dr. Michael Milne examined Petitioner at Respondent's request pursuant to Section 12 of the Act. Dr. Milne testified via evidence deposition on April 2, 2013. He testified that there was no structural change in Petitioner's knee as a result of the February 18, 2011 incident. He additionally opined that he did not believe that the knee was permanently aggravated as a result of the injury based on the MRI findings, indicating that he may have had a temporary aggravation of pain and swelling. He believed that the Petitioner's condition was likely related to his age, weight, history of smoking, history of prior knee complaints, family history and genetics.

CONCLUSIONS OF LAW

1. Regarding the issue of whether the Petitioner sustained an accident, the Arbitrator notes that the testimony of all the witnesses mentioned above raise questions of credibility. For this reason, the Arbitrator looks to the Petitioner's testimony, in which he describes the mechanism of injury as his leg being "pinned" between a semi truck trailer bumper and the pavement. Petitioner also described the semi truck trailer bumper rolling over his left leg and breaking his leg brace. Despite having a semi truck roll over his left leg, Petitioner did not attempt to seek medical treatment until after he was laid off over a month later in March, 2011. Despite his leg brace being destroyed when the semi truck rolled over his left leg, there is no indication that the Petitioner had any structural change to his leg according to the x-rays and MRI reports, much less any indication that the Petitioner sought to replace his broken leg brace.

Petitioner's description of what allegedly happened to his left leg is quite different from what is reported in Dr. Gurtler's records as a "twisting" injury. Finally, the fact that the Petitioner called occurrence witnesses, who themselves were less than credible, in addition to the facts indicated above, all lead to the conclusion that the Petitioner's testimony regarding his alleged accident lacked credibility. Accordingly, the Arbitrator finds that the Petitioner failed to meet his burden of proof regarding the issue of accident.

2. Based on the Arbitrator's findings regarding the issue of accident, all other issues are rendered moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Eduardo Hernandez,

Petitioner,

vs.

NO: 11WC 21040

14IWCC0227

Kemper Sports Mgmt. d/b/a The Glen Club,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, temporary total disability, permanent partial disability, prospective medical treatment, penalties, fees, and unspecified "evidentiary issues." and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 17, 2013, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

14IWCC0227

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 8 2014

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RWW/jrc
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

NOTICE OF 19(b) DECISION OF ARBITRATOR

HERNANDEZ, EDUARDO
Employee/Petitioner

Case# **11WC021040**

14IWCC0227

KEMPER SPORTS MGMT D/B/A THE GLEN CLUB
Employer/Respondent

On 7/17/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

4583 SOFFIETTI JOHNSON TEEGEN ET AL
DAVID J BAWCUM
74 E GRAND AVE PO BOX 86
FOX LAKE, IL 60020

0560 WIEDNER & MCAULIFFE LTD
EMILY BORG
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

14IWCC0227

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Eduardo Hernandez
Employee/Petitioner

v.

Kemper Sports Mgmt. d/b/a The Glen Club
Employer/Respondent

Case # **11 WC 21040**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **June 27, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other

FINDINGS

On the date of accident, **3/24/11**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being for the left hip is causally related to the accident, Petitioner's current condition of ill-being for the lumbar spine is not causally related to the accident.

In the year preceding the injury, Petitioner earned $**$18,200.00**; the average weekly wage was $350.00.

On the date of accident, Petitioner was 54 years of age, ***single*** with **0** dependent children.

Respondent ***RESERVED FOR LATER HEARING*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**$23,849.70** for TTD, $**n/a** for TPD, $**n/a** for maintenance, and $**n/a** for other benefits, for a total credit of $**$23,849.70**.

Respondent is entitled to a credit of $**n/a** under Section 8(j) of the Act.

ORDER

*Respondent shall pay temporary total disability of $**253.00** per week for **93-5/7** weeks commencing **3/31/11** through **1/14/13** . Respondent shall receive credit for amounts paid.*

Respondent shall pay to Petitioner reasonable and necessary medical expenses incurred through 1/14/13 except as delineated in the Decision pursuant to Section 8(a) of the Act. Respondent shall receive credit for amounts paid.

Petitioner's request for prospective lumbar surgery is denied. See Decision

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

David A. Kane
Signature of Arbitrator

July 16, 2013
Date

JUL 17 2013

14IWCC0227

STATE OF ILLINOIS } SS
COUNTY OF COOK

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Eduardo Hernandez,
Petitioner,
vs.
Kemper Sports Mgmt. d/b/a The Glen Club,
Respondent.

Case No. 11 WC 21040

ATTACHMENT TO ARBITRATOR'S DECISION

STATEMENT OF FACTS

The Arbitrator notes that with regard to the paragraph on the Decision form relating to temporary total disability, the proper rate is $253.00, due to the petitioner's status as married, as set forth on the Request for Hearing Stipulation form. TTD does not begin to run until March 31, 2011, as this is the first date off work claimed on the aforesaid Request for Hearing form.

The petitioner, Eduardo Hernandez, was employed with Kemper Sports Management, d/b/a The Glen Club, the respondent, on March 24, 2011. Petitioner testified at trial he was using a backpack leaf blower when he fell onto his left side. The medical records introduced at trial evince that petitioner presented to the emergency room At NorthShore University Health Systems on March 28, 2011, four days after the accident, reporting

left lower back and buttock pain. The medical indicated petitioner had no radiation of pain, nor numbness and tingling in his extremities. X-rays of the petitioner's pelvis revealed marked degenerative disc disease in the lumbar spine, along with degenerative arthritis in both hips, more pronounced in the left hip than the right hip. The left hip X-ray notes complete loss of superior joint space. Petitioner was diagnosed with only a hip contusion.

Petitioner returned to the emergency room at NorthShore University Health Systems on March 31, 2011. Petitioner complained of back pain with radiation in his left hip. X-rays of the lumbar spine revealed degenerative disc disease at L4 through S1 with advanced degenerative changes of the left hip. (PX 1).

Petitioner followed up with Dr. Oh at NorthShore University Omega in April of 2011. Dr. Oh's records of April 5, April 11 and April 18 note petitioner had complaints of left buttock and hip pain following the fall. Petitioner denied any radiation of pain below the hip and again denied any numbness or tingling in his lower extremities. The assessment from Dr. Oh remained gluteal contusion with exacerbation of left hip degenerative joint disease. As of April 18, 2011, Dr. Oh referred the petitioner to an orthopedic physician with a diagnosis of left hip pain. (PX 2).

Petitioner followed up with Dr. Koh on April 26, 2011. Dr. Koh noted petitioner was a grossly obese male who fell and suffered a contusion to his posterior left thigh and buttock. Petitioner reported pain primarily into the left groin area. X-rays demonstrated severe left hip osteoarthritis. Dr. Koh recommended an MRI of petitioner's left hip. The MRI was performed on May 2, 2011. On May 10, 2011, Dr. Koh reviewed the MRI and noted it demonstrated a significant edema in the femoral neck with what appeared

to be a small depression or fracture versus a large cyst. Severe arthritis of both the femoral and acetabular sides of the left hip was noted. Petitioner was to be referred to a joint replacement specialist. (PX 3).

Petitioner presented to Dr. O'Rourke at Illinois Bone & Joint on May 17, 2011. The medical history contained in Petitioner's Exhibit 4 indicates petitioner was only present for left hip pain. The location of symptoms was noted to be the "hip." Dr. O'Rourke recommended a total hip replacement on that first visit. (PX4)

The petitioner was independently evaluated under Section 12 by Dr. Walter Virkus. Dr. Virkus opined petitioner suffered from left hip osteoarthritis secondary to CAM lesion and femoral head avascular necrosis. In his report, Dr. Virkus offered the opinion that the condition was not caused by the work trauma, but that the pre-existing condition was temporarily aggravated by the fall. Dr. Virkus felt it was surprising that petitioner reported no pain in his hip prior to the accident, given the severe degeneration of the hip combined with the petitioner's excessive weight. Dr. Virkus felt petitioner's surgery was warranted based on the pre-existing condition. Dr. Virkus testified consistently at his deposition. (RX 4).

The petitioner saw Dr. O'Rourke again on February 7, 2012, where he presented with "left hip pain." The impression was advanced left hip osteoarthritis. Dr. O'Rourke again recommended total hip replacement surgery. Petitioner underwent a left total hip replacement on May 7, 2012, after a delay due to a complication from his diabetes. Petitioner continued to treat with Dr. O'Rourke following the hip replacement and was seen on May 24, June 21, July 19, and November 1, 2012. These medical records from Dr. O'Rourke do not contain notations of back pain. (PX4)

On November 1, 2012, petitioner was noted to have a positive straight leg raise on physical examination. At that time, Dr. O'Rourke recommended an MRI of the petitioner's lumbar spine. (PX 4). The MRI of petitioner's lumbar spine, performed on November 7, 2012, revealed posterior bulging at L4-L5 and L5-S1 indenting the L4-L5 nerve roots. On December 6, 2012, Dr. O'Rourke recommended a hip aspiration to rule out a low-grade infection and evaluation by a spine surgeon. (PX 4).

Petitioner saw Dr. Gary Shapiro on January 22, 2013. Two reports resulted from that visit. (PX4) Dr. Shapiro reviewed the MRI and diagnosed degenerative disc disease at L4-L5, L5-S1, with lumbar spinal stenosis with foraminal narrowing. In his first report, Dr. Shapiro noted that there was litigation regarding whether his back condition was related to the work injury. Dr. Shapiro stated, "I have not been able to review all of his medical records for this office visit. Certainly, I would be willing to do so in the future if these medical records were made available to me." (PX4)

Dr. Shapiro issued an addendum report, also dated January 22, 2013, where he added the paragraph that **based upon the history provided to him by the petitioner**, the petitioner had a permanent aggravation of his pre-existing condition of lumbar stenosis and degenerative disc disease. He noted petitioner had complaints of low back pain and buttock pain while at Glenbrook Hospital and has had persistent low back complaints that remain significant at that time. He noted petitioner did not have a prior history of lumbar spine problems pre-dating the accident.

Dr. Shapiro admitted on deposition that he did not have any of petitioner's medical records to review when he issued the addendum report

offering a causation opinion. When specifically questioned on Page 31 of the transcript, "So if the record suggested that petitioner did not complain of back pain consistently since the accident, would that change your opinion as to causation?" Answer: "It could." Dr. Shapiro admitted that his **opinions were based upon the petitioner's own representation that he had pain in his low back consistent from the date of accident forward.** Dr. Shapiro further admitted he was not aware of the specifics of the mechanism of the fall. Dr. Shapiro offered no opinions regarding whether petitioner's lumbar complaints were caused, aggravated or accelerated by any sequelae of petitioner's left hip injury. Petitioner offered no testimony his back pain was a sequelae of the hip condition or treatment.

The respondent had the petitioner independently evaluated by Dr. Michael Lewis on January 14, 2013 as Dr. Virkus relocated to Indiana. Dr. Lewis opined that while the petitioner's hip condition and left groin pain were caused by the alleged work trauma, the work trauma did not cause the low back condition. Dr. Lewis noted his opinion was based on the petitioner's representation that he did not have back pain until after the left hip replacement surgery, back pain was not mentioned in the records after the first 2 emergency room visits, as well as the fact that petitioner clearly had a pre-existing severe degenerative disc disease at L4-L5 and L5-S1. (RX3) In an addendum dated April 2, 2013, Dr. Lewis notes that while the initial emergency records do note pain in the low back area, it became apparent to the treating doctors that his injury was a fracture of the hip. He felt it was common for there to be initial confusion between the origin of pain in the hip area as to whether it was originating in the low back or the hip. The etiology of the pain was in petitioner's left hip, which was verified by subsequent X-ray, MRI and improvement after the surgery. Petitioner in

fact testified at trial that the groin pain and his hip pain had resolved as of the hearing. Dr. Lewis notes again that petitioner specifically told him that the low back pain began after his left hip surgery. Therefore, Dr. Lewis concluded the need for the spinal fusion was not related to the workplace fall almost two years prior. (RX3)

Petitioner did undergo multiple therapies after the hip replacement surgery. Of note, in Petitioner's Exhibit 1, the standing and aqua physical therapy records from NorthShore University Health System do not contain any references to low back pain, only hip and groin pain. The Accelerated Physical Therapy records from June through September of 2012 have a few notations of low back soreness, all of which occur after the hip replacement surgery, 15 months after the accident.

In support of the Arbitrator's decision as to whether the condition of ill-being was caused by the injury, and whether the prospective medical treatment is appropriate and related, the Arbitrator finds as follows:

The Arbitrator finds that the petitioner proved a compensable left hip fracture and that the subsequent left hip replacement surgery was causally related to the work injury of March 24, 2011. The Arbitrator further finds that petitioner failed to prove that his current lumbar complaints, now more than two years after the accident, are causally related to the March 24, 2011 left-sided fall. The Arbitrator further finds that the lumbar fusion surgery proposed by Dr. Shapiro is not causally related to that workplace incident.

It is fundamental that the petitioner has a burden of proving all elements of his right to recover by preponderance or a greater way to be evidenced. The right to recover must arise out of facts thus established and may not be based on speculation or conjecture. *Deere & Company v. Ind. Comm'n.*, 47 Ill.2d 144. The courts have consistently held that a claimant has the burden of proving by the preponderance of credible evidence all elements of the claim, including that any alleged state of ill being was caused by a workplace accident. *Parro v. Ind. Comm'n.*, 26D. Ill.App.3d 551 (1993). The Commission has clearly noted in the past that causal connection opinions are only as good as the facts upon which they are based. If the basis for the causal connection opinion is flawed in any way, the Commission may disregard said opinions. *Sorensen v. Ind. Comm'n.*, 281Ill.App.3d 373 (1996), *Horvath v. Ind. Comm'n.*, 96 Ill.2d 349 (1983).

It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical testimony. *Caterpillar Tractor Company v. Ind. Comm'n.*, 124 Ill.App.3d 650 (1984). Even when the evidence in the record might sustain a claim, such evidence is insufficient if it appears from all testimony and circumstances shown in the record that a finding is against the manifest weight of the evidence. *Board of Education of the City of Chicago v. Ind. Comm'n.*, 83 Ill.2d 475 (1981).

The evidence introduced at trial establishes that petitioner did have a compensable accident on March 24, 2011 when he fell onto his left side while blowing leaves on the golf course. The petitioner did seek immediate medical attention and has relayed a consistent history of hip pain with radiation from the groin around the hip. The left hip MRI did in fact reveal a probable compression fracture of the femoral head in the weight-bearing

area versus avascular necrosis. In addition, Respondent's Section 12 examining physician, Dr. Lewis, specifically provides in his January 14, 2013 report that petitioner's pre-surgical left groin pain was caused by the alleged work trauma, given that petitioner suffered immediate groin pain. He opined that petitioner's diagnosis was status post hip replacement, which appeared to have been a successful operation.

In an addendum, dated February 19, 2013, Dr. Lewis opined petitioner's left hip examination was normal at the time of the IME. Petitioner reported his pre-surgery groin pain had resolved. Indeed, at trial, petitioner testified his groin and hip pain had resolved. Dr. Lewis felt petitioner could return to work at his prior job as it relates to his left hip injury.

While the compensability of the hip injury is supported by the trial testimony and the medical evidence submitted at trial, the petitioner has failed to prove that his lumbar condition and the proposed surgery are related to the work accident. The Arbitrator notes that the petitioner's testimony was inconsistent with the medical evidence submitted at trial. Specifically, other than the emergency room records of March 28 and March 31, none of the medical records from Dr. O'Rourke, Dr. Koh, Dr. Oh, Dr. Kogan, the aqua therapy records or the physical therapy records from NorthShore University Health System contain any references to low back pain. Dr. O'Rourke, the primary orthopedic surgeon's records, do not even reference the low back until petitioner is nearing release at MMI at the end of 2012. Even when the petitioner is seen by Dr. O'Rourke in November of 2012, he does not specifically report low back pain. Dr. O'Rourke recommended the MRI because petitioner had a positive straight leg raise. Prior records from Dr. O'Rourke note a negative straight leg raise.

Given the inconsistencies in the medical records, the Arbitrator cannot rely on petitioner's representation that he suffered from low back pain from the date of accident forward. The Arbitrator notes petitioner sought no back treatment during the 19 month course of care for the hip, nor were any back complaints referenced in the medical records. The records however do contain consistent and repeated reports of groin and hip pain. The Arbitrator finds petitioner's assertion that he relayed back pain from the time of the fall to the IME physician unfounded. Dr. Lewis specifically opined in two reports that petitioner represented his back pain began after the hip replacement surgery. That assertion is supported by the medical evidence, which is devoid of low back complaints until after the hip surgery.

The only medical opinion causally relating the petitioner's lumbar spine condition to the workplace fall is flawed. Dr. Shapiro did not have an opportunity to review any of the medical records in this case. Dr. Shapiro admitted on deposition that his opinion was based upon petitioner's representation of back pain since the day of the fall. Dr. Shapiro admitted that if the petitioner's representations were not borne out in the medical records, his opinion on causation could change. Dr. Shapiro never offered the opinion that petitioner had an altered gait, or change in posture, which caused, aggravated or accelerated petitioner's lumbar spine condition.

Dr. Lewis's opinions negating causation were the most informed and most reliable. Dr. Lewis, unlike Dr. Shapiro, was privy to a review of the complete medical records. Dr. Lewis' report goes at length to detail every medical record he reviewed. Dr. Lewis offered the supported position that petitioner's pre-existing severe spinal stenosis at L4-L5 and L5-S1 was not caused by the work trauma. He noted that because the back pain did not

begin until several months after the alleged injury, the back pain would not be work-related. He also noted petitioner's representation that the back pain did not begin until after his left hip replacement. In his addendum, Dr. Lewis clarified that, although the petitioner had initial back pain complaints, the pain was noted primarily to be in his left groin area. Indeed, the March 28, 2011 emergency room records contain only a diagnosis of a hip contusion. Dr. Lewis explained that it became clear to the physicians treating the petitioner that the pain was related to the fracture in the petitioner's hip, as verified by X-ray and MRI. Again, Dr. Lewis opined that since the back pain did not begin until after the spinal surgery, which is supported by the medical evidence, the condition was not related to the alleged fall.

As the Arbitrator finds that the petitioner's allegation that his back pain was continuous after the accident is unreliable, he relies instead upon the clear and supported opinions of Dr. Lewis and the medical evidence in denying the lumbar fusion surgery.

Compensation has been similarly denied in numerous other cases based upon the lack of corroborative medical histories, conflicting medical histories and/or lack of claimant credibility. *McRae v. Ind. Comm'n.*, 285 Ill.App.3d 448 (1996); *Banks v. Ind. Comm'n.*, 134 Ill.App.3d 312 (1985); *Luby v. Ind. Comm'n.*, 82 Ill.2d 353 (1980). The Arbitrator notes oral testimony in conflict with contemporaneous documentary evidence deserves little weight. *United States v. United States Gypsum Company*, 333 U.S. 364 (1947).

In support of the Arbitrator's decision relating to whether TTD benefits are due and owing, the Arbitrator finds as follows:

Having failed to establish causal connection for the lumbar condition, the Arbitrator denies petitioner's claim for TTD benefits after January 14, 2013. Petitioner testified at trial that his hip and groin pain has resolved. Dr. Lewis opined that at the time of his evaluation, the physical examination of petitioner's left hip was essentially normal and symmetrical with the right hip. He felt the surgery was successful and that petitioner's groin pain, which was present prior to the surgery, was no longer present. Dr. Lewis specifically opined petitioner could return to work full duty as it relates to his left hip.

In support of the Arbitrator's decision relating to whether penalties and fees should be assessed against the respondent in this case, the Arbitrator finds as follows:

The Arbitrator finds that no penalties are due and owing in this case. Section 19(k) penalties are imposed where there has been an unreasonable or vexatious delay in payment of compensation, or proceedings have been instituted by the employer which are frivolous or for the purpose of delay. *Boker v. Illinois Ind. Comm'n.*, 14 Ill.App.3d 51 (1986). Section 16 fees are awarded when an employer has engaged in an unreasonable or vexatious delay, intentional underpayment, or frivolous defenses under Section 19(k). Unlike other penalties under the Act that are mandatory, the award of substantial penalties under Section 19(k) and

attorney's fees under Section 16 is discretionary. *McMahon v. Ind. Comm'n.*, 183 Ill.2d 499 (1998).

The Illinois Supreme Court in *McMahon* noted that the imposition of Section 19(k) and Section 16 attorney's fees requires a higher standard than the award of additional compensation under 19(l). Further, the Court noted that Section 19(k) and 19(l) penalties were intended to address different situations, with 19(k) providing substantial penalties in positions which are discretionary rather than mandatory. Section 16 includes language identical to the language of 19(k), and was intended to apply in the same type of circumstances. Section 19(l) provides for the imposition of a penalty where the employer, without good or just cause, fails to pay or delays payment of TTD benefits. The respondent in this matter did pay TTD benefits in good faith up through February 19, 2013, despite the opinions from Dr. Virkus that the workplace fall did not result in the severe osteoarthritis of petitioner's left knee, and that absent the injury, petitioner would have required hip replacement surgery. Despite this report, the respondent paid for the left hip replacement and all accompanying TTD benefits.

The denial of further TTD benefits is based upon the medical opinions of Dr. Lewis, which are supported by the medical records introduced into evidence by the petitioner at trial. As the Arbitrator has found that the petitioner's lumbar condition is not related to the workplace fall, any TTD benefits associated with the lumbar condition are hereby denied. In addition, the Arbitrator notes that it was not until petitioner was one month prior to discharge by Dr. O'Rourke for the left hip that the spinal surgery evaluation was recommended.

Therefore, the Arbitrator finds that no penalties or fees should be awarded against the respondent in this case.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael McNulty,
Petitioner,

vs.

NO: 09WC 42326
10WC 04999

14IWCC0228

Averitt Express, Inc,
Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) and 8(a) having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, temporary total disability, causal connection and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 1, 2013, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

14IWCC0228

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $3,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 8 2014

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RWW/jrc
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

# ILLINOIS WORKERS' COMPENSATION COMMISSION
# NOTICE OF 19(b) DECISION OF ARBITRATOR
8(a)

McNULTY, MICHAEL
Employee/Petitioner

Case# **09WC042326**

10WC004999

14IWCC0228

AVERITT EXPRESS INC
Employer/Respondent

On 7/1/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

4984 ROBIN LAW OFFICE
SHAWN M ROBIN
30 N LASALLE ST SUITE 1210
CHICAGO, IL 60602

1337 KNELL & KELLY LLC
CHARLES D KNELL
504 FAYETTE ST
PEORIA, IL 61603

14IWCC0228

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b) and 8(a)

Michael McNulty
Employee/Petitioner

v.

Averitt Express, Inc.
Employer/Respondent

Case # **09** WC **42326**

Consolidated cases: **10 WC 4999**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Chicago**, on **January 25, 2013** and **March 15, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[x] TPD [ ] Maintenance [x] TTD
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **causal connection; medical bills; TTD; TPD; + prospective medical**

FINDINGS

On the date of accident, **July 6, 2009**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being ***is not*** causally related to the accident as explained *infra*.

In the year preceding the injury, Petitioner earned **$14,217.84**; the average weekly wage was **$273.42**.

On the date of accident, Petitioner was **46** years of age, ***single*** with **3** dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services as explained *infra*.

Respondent shall be given a credit of **$7,192.08** for TTD, **$3,034.45** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$10,226.53**. *See* AX1-AX2.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner's claimed current condition of ill being is not causally related to his accident on July 6, 2009 or January 8, 2010. As explained in the Addendum, the Arbitrator finds as follows:

Respondent shall pay Petitioner temporary total disability benefits of $273.42/week for 24 weeks, commencing July 7, 2009 through December 21, 2009, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from July 6, 2009 through January 25, 2013, and shall pay the remainder of the award, if any, in weekly payments. Respondent shall be given a credit of $7,192.08 for temporary total disability benefits and $3,034.45 for temporary partial disability benefits that have been paid. Petitioner's claim for further temporary total disability and temporary partial disability benefits is denied.

Respondent shall pay reasonable and necessary medical services of Advanced Occupational Medicine Specialists bills reflected in PX12 as provided in Sections 8(a) and 8.2 of the Act. The bills from MedFinance which were purchased from Dr. Citow, Dr. Vargas, Dr. Michael, Libertyville Imaging, Lake County Anesthesiologists, Dr. Thakkar, and out-of-pocket costs paid to Dr. Citow are denied.

Petitioner's claim for penalties and fees under Sections 19(k), 19(l) or 16 of the Act is denied.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

June 27, 2013
Date

ICArbDec19(b)

JUL -1 2013

14IWCC0228

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*
19(b) and 8(a)

Michael McNulty
Employee/Petitioner

v.

Averitt Express, Inc.
Employer/Respondent

Case # **09** WC **42326**

Consolidated cases: **10 WC 4999**

FINDINGS OF FACT

A consolidated hearing was held in both of Petitioner's cases. The issues in dispute in the above-captioned cases involve causal connection, Respondent's liability for certain medical bills, a period of temporary total disability benefits, a period of temporary partial disability benefits, penalties and fees pursuant to Sections 16, 19(k), 19(l), and Petitioner's entitlement to prospective medical care for the low back. *See* Arbitrator's Exhibit ("AX") 1 and AX2; January 25, 2013 Arbitration Hearing Transcript; March 15, 2013 Arbitration Hearing Transcript. The parties have stipulated to all other issues.

Background

Petitioner testified that he was a dock worker employed by Respondent on the date of accident. His duties included loading and unloading trailers and sometimes moving containers in the yard using a "mule," which is a tractor utilized to hook, move, and pull around containers. Petitioner testified he was required to perform heavy lifting of objects anywhere from 5-100/200 pounds. A job description signed by Petitioner on July 10, 2009 reflects that Petitioner's essential functions included: (1) loading and unloading freight up to 80 pounds; (2) moving freight up to 54 pounds; (3) lifting and opening trailer doors up to 46 pounds; (4) counting freight; (5) operating a scanner; (6) completing manifests; (7) operating a forklift; and (8) regular predictable attendance. PX3 at 6. A nonessential function was hooking and unhooking trailers up to 90 pounds. *Id.*

Prior to July 6, 2009, Petitioner testified that he had no medical problems or medical treatment for conditions related to his neck or back. Petitioner is diabetic, has a heart condition, and had surgery to the left elbow/shoulder prior to his first injury where a muscle was pulled back into place. The records reflect that Petitioner had left rotator cuff surgery in 2007. PX3 at 36.

July 6, 2009 Injury

On the date of accident, Petitioner testified that he was injured when a large wall of safety glass fell on top of him and pinned him between two walls of glass. Petitioner testified that the top glass wall weighed approximately 600 pounds. Petitioner recalled waking up and trying to breathe and later being removed by a coworker from under the glass. He also testified that he had back pain, right leg pain, left elbow pain, chest/stomach pain, knee pain, pain, hand pain, and the taste of blood in his mouth. Petitioner did not testify that he experienced neck pain. Petitioner testified that he drove himself to Loyola hospital.

The medical records reflect that Petitioner went to Loyola's emergency room on July 6, 2009. PX2. Petitioner reported handling a large piece of glass (600 lbs.) which slipped and pinned him against the trailer mostly on the right side. PX2 at 10. Petitioner underwent left elbow, chest, abdomen, and pelvis x-rays. PX2 at 9-10. The

left elbow x-ray showed no fracture, dislocation, or joint effusion. *Id.* The remaining x-rays were essentially normal. *Id.* On examination, Petitioner exhibited pain localized to the upper abdomen/coastal margin both sides with palpation of ribs associated with voluntary guarding, pain on palpation of the right iliac crest, and pain on palpation and movement of the left elbow. PX2 at 12. Petitioner was discharged without restrictions and instructed to follow up if needed. PX2 at 32-33.

On July 8, 2009, Petitioner went to Advanced Occupational Medicine Specialists and saw a certified physician's assistant, Erica Becker, PA-C ("Ms. Becker"). PX3 at 1-11. Petitioner reported right hip, left elbow, right chest wall pain as well as pain with deep inhalation, nausea, and one episode of vomiting without blood. *Id.* petitioner did not report any neck or low back pain. *Id.* On examination of the hips, Petitioner had tenderness on the right posterior-superior iliac spine and sacral iliac joint and a 16 cm x 6 cm area of ecchymosis on the right interior quadricep. *Id.* On examination of the back, Petitioner had pain with lateral rotation to the left, pain with side bending to the right, pain on supine straight leg raises on the right, tenderness to palpation on the T1-2 spinous process and L5 to S1 spinous processes, and tenderness to palpation from L3 to S1 right paraspinous muscles with spasm. *Id.* Petitioner's left elbow examination showed pain and numbness with Tinel's sign and maximal tenderness at the lateral epicondyle and along the extensor muscles of the forearm. *Id.* Petitioner also had tenderness to palpation along his right side and anterior ribs, in the right upper quadrant and lower left quadrant, and along the rectus abdominus muscles. *Id.*

Ms. Becker diagnosed Petitioner with a right chest wall contusion, right abdominal strain, right sacroiliitis, right abdominal contusion, left lateral epicondylitis, right paraspinal muscle strain, and right paraspinal muscle spasm. *Id.* She restricted Petitioner to sedentary work only with instructions to alternate sitting and standing as tolerated, and no driving a forklift, bending, squatting, pushing, pulling, or lifting. *Id.* Ms. Becker also ordered an arm brace for the left elbow, prescribed ibuprofen 800 mg and cyclobenzaprine 10 mg, and scheduled a follow-up visit with Dr. Bender on July 10, 2009. *Id.*

Petitioner saw Dr. Bender on July 10, 2009. PX3 at 4, 12-14. Petitioner reported chest/abdomen pain, right hip/back pain, and left elbow pain. *Id.* Petitioner did not report any neck pain. *Id.* She diagnosed Petitioner with a full body crush injury, intestinal trauma, lumbago, right sacroiliitis, lateral epicondylitis, and paraspinous muscle spasm and kept Petitioner on light duty work. *Id.*

Petitioner returned on July 15, 2009 at which time Dr. Bender ordered further diagnostic tests and physical therapy three times per week for two weeks. PX3 at 15-20. Petitioner reported low back pain with radiation to the low abdomen/groin, chest pain, and left elbow pain, but did not report any neck pain. *Id.* Petitioner underwent an initial physical therapy evaluation for the left lateral epicondylitis at Advanced Occupational Medicine Specialists on July 24, 2009. PX3 at 36-37. Petitioner completed the occupational therapy on August 4, 2009. PX3 at 49.

Petitioner underwent the recommended lumbar spine MRI with and without contrast on July 20, 2009. PX3 at 21-22. The interpreting radiologist noted the following: (1) a disc protrusion at L2-3 with end plate degenerative changes and kyphotic angulation and moderate to severe neural foraminal narrowing bilaterally; (2) scattered mild other degenerative changes as above with mild neural foraminal narrowing at L3-4, L4-5, and L5-S1; and (3) a small focus of susceptibility artifact within the inferior end plate of L2 of uncertain etiology possibly related to a prior surgery. *Id.*

On July 22, 2009, Dr. Bender noted that it was Petitioner's "1st visit today for back pain" which radiated to his right leg and updated Petitioner's diagnoses to a full body crush injury, intestinal trauma (worse), L2-L3 disc

protrusion with foraminal narrowing, L1-S1 facet hypertrophy, left lateral epicondylitis, paraspinous muscle spasm (worse), and a right scaphoid contusion. PX3 at 23-27. Petitioner did not report any neck pain. *Id.* She kept Petitioner on light duty work and ordered additional physical therapy three times per week for two weeks. *Id.*

Petitioner underwent an initial physical therapy evaluation for left lateral epicondylitis on July 24, 2009 and he reported having no pain or discomfort localized to the left elbow before his incident at work. PX3 at 36-37. He had an initial physical therapy evaluation related to his lumbago/suspected HNP at Advanced Occupational Medicine Specialists on July 30, 2009. PX3 at 28-30. Petitioner completed the physical therapy on August 3, 2009. PX3 at 49.

Petitioner returned to Dr. Bender on August 5, 2009. PX3 at 49-53. Petitioner reported low back pain at a level of 8-9/10, left elbow pain at a level of 5/10, and no right wrist pain. *Id.* Petitioner did not report any neck pain. *Id.* Dr. Bender examined Petitioner and updated his diagnoses to a full body crush injury, intestinal trauma (same), L2-L3 disc protrusion (same), left lateral epicondylitis (slightly improved), and a right scaphoid contusion (resolved). *Id.* She kept Petitioner on light duty work restrictions, ordered an abdominal CT scan, and referred Petitioner to Dr. Vargas, a pain management specialist, for an epidural steroid injection consultation. *Id.*

Petitioner underwent the recommended abdominal CT scan on August 11, 2009. PX3 at 54. The interpreting radiologist noted the following: (1) slightly enlarged prostate with thickened bladder wall; (2) occasional diverticula sigmoid colon; and (3) spondylolysis at L5 with suspicion of spondylolisthesis at L5-S1. *Id.* He also noted degenerative changes in the upper lumbar spine. *Id.*

On August 14, 2009, Petitioner saw Dr. Bender. PX3 at 55-60. Petitioner reported low back pain, right buttock paresthesias (intermittent), less abdominal pain, and no right wrist pain. *Id.* Petitioner did not report any neck pain. *Id.* Dr. Bender examined Petitioner and updated his diagnoses to a full body crush injury, intestinal/abdominal trauma (improved), L2-L3 disc protrusion (same), left lateral epicondylitis (improved). *Id.* She kept Petitioner on light duty work restrictions and ordered additional physical therapy for the left lateral epicondylitis three times per week for two weeks. *Id.*

Petitioner initially saw Dr. Vargas at River North Pain Management Consultants on August 22, 2009. PX3 at 61-64; PX4 at 45-51. Petitioner reported approximately 6 to 7 weeks of progressively worsening distal lower back pain with associated right sided lower extremity sciatica symptoms soon after his injury at work. *Id.* Dr. Vargas noted that Petitioner was a poor historian, but Petitioner informed Dr. Vargas that he was injured at work when he was pinned under a 500 pound piece of glass. *Id.*

During his examination, Petitioner reported constant, sharp, stabbing, shooting, electrical-like pain at the distal lower back that radiated caudally into both buttocks progressing further distantly via a postero-lateral route into both thighs, calves, ankles, and feet more so on the right. *Id.* He also reported paresthesia described as a tingling sensation from L2-L4 more so on the right at L2-L3, frank neurological claudication, a mild foot drop, pain ranging from 6/10 to 9-10/10 worsened with ambulation, increased pain with transfers, and ameliorated pain lying down with knees flexed. *Id.*

Among other findings, Dr. Vargas noted that Petitioner had a mild limp favoring his left lower extremity, he climbed onto the examining table with some difficulty, he had decreased range of motion in the lumbosacral spine, he was unable to toe walk or heel walk, he was unable to squat upon request due to "mild exacerbation"

of his pain, he had mild weakness at the right sided biceps femoris, "mild but relevant" right-sided foot drop, and mild hyporeflexia to the left patellar and Achilles tendon. *Id.* He diagnosed Petitioner with multilevel lumbosacral spondylosis, multilevel degenerative disc disease and facet arthropathy, bilateral L2-L3 neural foraminal stenosis, and discogenic L2-L3 radiculopathy. *Id.* Dr. Vargas noted that Petitioner's "clinical presentation [was] somewhat perplexing, as most of his symptoms seem to be right-sided, although he presents a bilateral neuroforaminal stenosis." *Id.* He ordered a series of transforaminal epidural steroid injections. *Id.*

On August 24, 2009, Petitioner returned to Dr. Bender and reported low back pain with right buttock paresthesias, less abdominal pain, left elbow pain at a level of 3-4/10, abdominal pain at a level of 2/10, and epigastric pain. *Id.* Petitioner did not report any neck pain. *Id.* Dr. Bender maintained her diagnoses of Petitioner's condition, Petitioner on light duty, noted that the injections recommended by Dr. Vargas had not yet been approved, and ordered additional physical therapy for Petitioner's lumbago and left lateral epicondylitis. PX3 at 65-67.

Petitioner underwent the first epidural steroid injection with Dr. Vargas on August 29, 2009. PX3 at 71-72; PX4 at 35-44.

Petitioner returned to Dr. Bender on September 8, 2009 and reported low back pain at a level of 7-8/10, right buttock paresthesias (constant) with PS at a level of 10/10 (intermittently), left elbow pain at a level of 8/10 (occasionally), and some epigastric pain. *Id.* Petitioner did not report any neck pain. *Id.* Dr. Bender updated Petitioner's diagnoses to a full body crush injury, intestinal trauma (improved), left lateral epicondylitis (resolved), and lumbago with L2/L3 disc protrusion. PX3 at 77-81. She kept Petitioner on light duty work restrictions, discontinued his use of the left forearm splint, and ordered the completion of the previously ordered physical therapy for the left lateral epicondylitis three times per week for two weeks. *Id.*

Petitioner returned to Dr. Vargas on September 10, 2009[1]. PX3 at 84-86; PX4 at 27-28. Petitioner reported a significant improvement of his overall lower back pain and radicular symptoms within 24-36 hours up his first injection, intermittent pain and stiffness in the distal lower back with radiation mostly into the right buttock, no left sided symptoms, and overall improvement of 30-40% decrease in overall symptoms, and lessened pain at a level of 5/10. *Id.* Dr. Vargas maintained his diagnoses of Petitioner and recommended continuation of the epidural steroid injection series. *Id.* The second injection was administered on September 17, 2009. PX3 at 88-89; PX4 at 24-34.

Petitioner returned to Dr. Bender on September 22, 2009. PX3 at 90-92. He reported left elbow pain at a level of 2/10, back pain at a level of 8-9/10, right buttock to right knee paresthesias pain, left leg paresthesias pain to the knee, epigastric pain at a level of 4/10, and constipation. *Id.* Petitioner did not report any neck pain. *Id.* Dr. Bender updated Petitioner's diagnoses to a full body crush injury, L2/L3 disc protrusion, lumbago (worsened), bilateral leg paresthesias (worse), and left lateral epicondylitis (improved). *Id.*; *Cf.* PX3 at 77-81 (September 8, 2009 diagnosis of resolved left lateral epicondylitis) and PX3 at 1-76 (no prior diagnosis of leg paresthesias from Dr. Bender or Ms. Becker). She kept Petitioner on light duty work restrictions, referred Petitioner to Dr. Vargas for evaluation of a possible spinal headache, and ordered the completion of the previously ordered physical therapy for the left lateral epicondylitis three times per week for two weeks. *Id.*

[1] The Arbitrator notes that the date of service listed in Dr. Vargas' progress note is August 22, 2009; however, Dr. Vargas' records contain the same progress noted dated September 10, 2009 which also refers to last seeing Petitioner on August 29, 2009 and he ordered physical therapy under the direction of Dr. Bender in a handwritten script dated September 10, 2009. PX3 at 84-86. The Arbitrator further notes that this progress note appears to have been faxed by or to Advanced Occupational Medicine Specialists on September 17, 2009. *Id.*

On September 29, 2009, Petitioner saw Dr. Vargas. PX3 at 96-97; PX4 at 21-22. Dr. Vargas noted a conversation with Petitioner during the prior week wherein Petitioner reported developing progressive postural occipital-temp oral headaches, mild photophobia, and prostration within 24-36 hours of his second injection. *Id.* Dr. Vargas further noted that as Petitioner's "overall symptoms worsened further… I recommended for him to undergo a product epidural autologous blood patch (EBP)." *Id.* He maintained his diagnoses of Petitioner and added a diagnosis of post-dural puncture headache (PDPH). *Id.* Petitioner underwent the recommended epidural autologous blood patch on October 3, 2009. PX3 at 100-101; PX4 at 11-20.

Petitioner returned to Dr. Bender on October 6, 2009. PX3 at 105-106. Petitioner reported right buttock pain and paresthesias to the right knee at a level of 7-8/10, and left elbow pain at a level of 0-1/10. *Id.* Dr. Bender updated Petitioner's diagnoses to a full body crush injury, L2/L3 disc protrusion, lumbago (slightly improved), bilateral leg paresthesias (worse), and left lateral epicondylitis (resolved). *Id.*; *Cf.* PX3 at 77-81 (September 8, 2009 diagnosis of resolved left lateral epicondylitis) and PX3 at 90-92 (September 22, 2009 diagnosis of improved left lateral epicondylitis). Petitioner did not report any neck pain. *Id.* Dr. Bender ordered additional physical therapy for Petitioner's lumbago on October 6, 2009 three times per week for an additional four weeks. PX3 at 103. She also ordered a functional capacity evaluation. PX3 at 104.

On October 15, 2009, Dr. Vargas administered Petitioner's third epidural steroid injection. PX3 at 107-108; PX4 at 2-10. Petitioner testified that the injections with Dr. Vargas were not helpful.

Petitioner saw a new doctor for his spine, Dr. Michael. PX3 at 116. On October 19, 2009, Petitioner saw Dr. Michael at the Illinois Neurospine Institute. PX3 at 109; PX5 at 14-18. Petitioner provided a history of his work accident including a reported loss of consciousness, pain from his head to his right knee, low back pain "much, much worse than associated right leg pain[,]" severe pains with sitting/standing/walking, particular discomfort with driving and bumpy roads, numbness and tingling in the right second through fourth toes, neck pain and headaches which were bilaterally occipital, and no arm pain, numbness, tingling, or weakness. *Id.* Dr. Michael reviewed Petitioner's low back MRI which he interpreted to show L2-L3 loss of disc space height, degenerative changes, endplate changes with broad-based protrusion, and L5-S1 desiccation and protrusion with possible L5 bilateral spondylosis. *Id.* On examination, Petitioner had a negative bilateral straight leg raise test. *Id.*

Dr. Michael ordered a cervical spine MRI for neck pain and a lumbar spine five view MRI to rule out spondylolysis. *Id.* He diagnosed petitioner with pre-existing L2-L3 degenerative disc disease and L5-S1 disc degeneration with possible spondylolysis that were "clearly causally aggravated by the work-related injury." *Id.* Dr. Michael also diagnosed petitioner with non-specific cervicalgia. *Id.* He did not indicate whether this condition was causally related to his injury at work and he did not impose any work restrictions on Petitioner related to any of his diagnoses. *Id.*

Petitioner underwent a cervical spine MRI on October 26, 2009. PX3 at 115. The interpreting radiologist noted the following: disc bulging/bony proliferation at C5-6 and C6-7 levels, significant narrowing of the left neural foramen at C6-7, and no central canal stenosis. *Id.*

Petitioner returned to Dr. Bender on October 27, 2009. PX2 at 116-118. He reported no left elbow pain, back pain and right middle [illegible] pain at a level of 7/10, lower right leg pain to the calf area, and increased pain with extended sitting. *Id.* Petitioner did not report any neck pain. *Id.* Dr. Bender updated Petitioner's diagnoses to a full body crush injury, L2/L3 disc protrusion status post three epidural steroid injections with Dr.

Vargas, lumbago (same), bilateral leg paresthesias (same on the left, resolved on the right), and left lateral epicondylitis (resolved). *Id.*; *Cf.* PX3 at 77-81 (September 8, 2009 diagnosis of resolved left lateral epicondylitis) and PX3 at 90-92 (September 22, 2009 diagnosis of improved left lateral epicondylitis). She kept Petitioner on light duty work restrictions, ordered continued physical therapy for Petitioner's lumbago as previously ordered on October 6, 2009, and renewed her order for a functional capacity evaluation. *Id.*

First Section 12 Examination – Dr. Wehner

On November 16, 2009, Petitioner submitted to an independent medical evaluation with Dr. Wehner at Respondent's request. PX3 at 135-136; RX11. Petitioner reported sustaining an injury on July 6, 2009 when 500 pounds of glass fell off the truck onto him hitting his head and back. *Id.* On examination, Petitioner appeared in mild distress, had a normal gait pattern, reported low back pain with heel walking on the right, had normal toe walking, and could bend and touch his toes on the left, but only to the mid-tibia on the right. *Id.* Petitioner had some mild pain with right S1 joint palpation, axial compression or axial rotation. *Id.* He had no paraspinal spasm or scoliosis, a negative straight leg raise, knee and ankle reflexes at 2+, motor strength at 5/5, painless range of motion in the hip, and mildly stiff figure 4 testing. *Id.* Dr. Wehner reviewed various treating medical records including diagnostic test results through October 26, 2009. *Id.*

Ultimately, she diagnosed Petitioner with back pain with right leg pain in a radicular pattern, status post crush injury contusion to the back. *Id.* Dr. Wehner noted that it appeared that Petitioner had only undergone three weeks of physical therapy, and thus, she recommended another three weeks of physical therapy focusing on lumbar stabilization and restricted him to light duty work only with no lifting over 20 pounds. *Id.* Dr. Wehner did not recommend a discogram (as recommended by Dr. Michael) given that Petitioner had only undergone three weeks of physical therapy and it had only been four months since his date of injury; she recommended a discogram at six months if Petitioner did not improve with further conservative treatment. *Id.* Dr. Wehner further noted that Petitioner had significant pre-existing degenerative changes at L2-3 and that he may benefit from a fusion if he continued to have pain. *Id.* She noted that Petitioner denied any baseline back problems pre-existing his injury, but that the radiologic findings of disc degeneration at L2-3 preexisted his injury at work. *Id.*

Continued Medical Treatment

On November 23, 2009, Petitioner saw Dr. Michael. PX5 at 12. He reported continued and worsened low back pain, right leg pain, neck pain, and left shoulder pain. *Id.* Dr. Michael noted that Petitioner was unchanged neurologically. *Id.* He reviewed Petitioner's cervical spine films which showed C5-C6 and C6-C7 disc protrusions with left C6-C7 and narrowing and lumbosacral spine films which he believed showed spondylolysis at L5. *Id.* He diagnosed Petitioner with L2-L3 degenerative disc disease and L5-S1 degeneration for which he recommended a lumbar discogram and post-discogram CT to definitively determine whether Petitioner had spondylolysis. *Id.* Dr. Michael did not indicate whether Petitioner's neck condition was causally related to his injury at work and he did not impose any work restrictions on Petitioner related to any of his diagnoses. *Id.*

On November 30, 2009, Petitioner saw Dr. Bender. PX3 at 128-129. Petitioner reported feeling the same with no improvements, having undergone an independent medical examination on November 16, 2009, decreased numbness, right leg still the same, intermittent left elbow pain, and inability to sit over 20-30 minutes before experiencing back pain. *Id.* Dr. Bender updated Petitioner's diagnoses to a full body crush injury, L2/L3 disc protrusion status post three epidural steroid injections with Dr. Vargas getting injection from Dr. Michael on 12/3/09, lumbago (same), right leg paresthesias (same), left leg paresthesias (resolved) and intermittent left

lateral epicondylitis pain. *Id.*; *Cf.* PX3 at 77-81 (September 8, 2009 diagnosis of resolved left lateral epicondylitis) and PX3 at 90-92 (September 22, 2009 diagnosis of improved left lateral epicondylitis) and PX3 at 116-118 (October 27, 2009 diagnosis of resolved right leg paresthesias). She kept Petitioner on light duty work restrictions and ordered a TENS unit per Dr. Vargas' instructions. *Id.*

Petitioner underwent the recommended discogram with Dr. Michael on December 3, 2009 for L2-L3 degenerative disc disease and L5-S1 degeneration and saw him thereafter on December 7, 2009 at which time he reported low back and leg pain. PX5 at 9-11. Dr. Michael found L2-L3 and L5-S1 discs were pathologic on tension, morphological, and pain provocation. *Id.* Dr. Michael reiterated his causal connection between Petitioner's low back condition and his work accident, but he did not indicate whether Petitioner's neck condition was causally related. *Id.* He did not impose any work restrictions on Petitioner related to any of his diagnoses. *Id.*

On December 15, 2009, Petitioner saw Dr. Bender. PX3 at 131-133. Petitioner reported feeling the same, feeling and occasional pop in the left elbow, decreased pain in the right leg a bit better, numbness, and having undergone a discogram one week earlier. *Id.* Dr. Bender updated Petitioner's diagnoses to a full body crush injury, right leg paresthesias (same), left leg paresthesias (resolved), lumbago (same), L2-L3 disc protrusion, and intermittent left lateral epicondylitis pain. *Id.* She kept Petitioner on light duty work restrictions and recommended use of the TENS unit per Dr. Vargas' instructions. *Id.*

On cross examination, Petitioner acknowledged that he had no physical therapy for his neck from July of 2009 through December of 2009, he returned to work on December 22, 2009, and he continued to work through September 13, 2010.

January 8, 2010 Injury

On re-direct examination, Petitioner testified that he was reared ended by a forklift and experienced a burning sensation in his neck and his head became hot. Petitioner did not testify at trial about any low back symptomatology immediately following his second accident. On cross examination, Petitioner testified that he did not go to the hospital, but rather went to the clinic.

On January 9, 2010, Petitioner called Dr. Bender. PX3 at 138. He reported being hurt the prior day [January 8, 2009] at work while driving a forklift and was hit from behind. *Id.* Petitioner reported experiencing immediate increased neck and back pain. *Id.* Petitioner had missed an appointment with Dr. Michael on January 4, 2010, and with Dr. Bender on January 8, 2010. *Id.* Dr. Bender offered Petitioner the opportunity to "come now to be evaluated, he declined." *Id.* A follow-up appointment was scheduled for January 11, 2010. *Id.*

On cross examination, Petitioner acknowledged that he worked part-time from January 10, 2010 through September 13, 2010 when Dr. Citow took him off work completely.

On January 11, 2010, Petitioner saw Dr. Bender. PX3 at 139-141; PX5 at 8. He reported being hit from behind while in a forklift on January 7, 2010 with neck and back pain at a level 10/10, pain radiating from his head to his right foot, worsened numbness, and increased left arm pain with sitting. *Id.* Dr. Bender updated Petitioner's diagnoses to a full body crush injury, lumbago (worse), right leg paresthesias (worse), left lateral epicondylitis (resolved), and neck pain with spasm. *Id.*; *Cf.* PX3 at 77-81 (September 8, 2009 diagnosis of resolved left lateral epicondylitis) and PX3 at 90-92 (September 22, 2009 diagnosis of improved left lateral epicondylitis). She kept Petitioner on light duty work restrictions. *Id.*

On January 11, 2010, Petitioner also saw Dr. Michael. PX3 at 143; PX5 at 7-8. He reported low back pain, right leg pain, severe neck and arm pain, and a "hot" feeling in his neck. *Id.* Dr. Michael noted that, regrettably, Petitioner returned to work without his authorization[2] and was rear-ended by a forklift. *Id.* He maintained that Petitioner had L2-L3 degenerative changes with L5-S1 disc degeneration, discogenic pain from L3-S1, and C5-C7 disc protrusions. *Id.* Dr. Michael stated that Petitioner's low back condition was related to his accident at work and the aggravating accident at work. *Id.* He did not causally relate Petitioner's neck condition to either accident. *Id.* Dr. Michael commented that Petitioner was inappropriately return to work and not told to be off his medications while working which was "negligent" on the clinic physician's part. *Id.* He placed Petitioner off work for four weeks. *Id.*

On January 21, 2010, Petitioner saw Dr. Bender. PX3 at 144-146. He did not have a scheduled appointment that day, but reported neck pain radiating to the forehead at a level of 10/10 preventing sleep and tolerable lower back at a level of 8/10 and left elbow pain at a level of 2/10. *Id.* Dr. Bender updated Petitioner's diagnoses to a cervical strain, muscle spasm, and neck pain. *Id.* She kept Petitioner on light duty work restrictions and ordered physical therapy for Petitioner's neck. *Id.*

On February 8, 2010, Petitioner returned to Dr. Bender. PX3 at 147-149. He reported low back pain at a level of 8/10, left elbow pain at a level of 0-10/10 with popping, right buttock and posterior thigh pain at a level of 9/10, and neck pain at a level of 9/10. *Id.* Dr. Bender administered a corticosteroid injection into the left epicondyle. *Id.* Dr. Bender updated Petitioner's diagnoses to a full body crush injury, lumbago (improved), left lateral epicondylitis (worse), L2-3 disc bulge, and C5-6 and C6-7 disc bulge (etiology unclear if work related). *Id.*; *Cf.* PX3 at 77-81 (September 8, 2009 diagnosis of resolved left lateral epicondylitis), PX3 at 90-92 (September 22, 2009 diagnosis of improved left lateral epicondylitis), and PX3 at 139-141 (January 11, 2010 diagnosis of resolved left lateral epicondylitis). She kept Petitioner on light duty work restrictions, ordered a left forearm splint, and continued use of the TENS unit. *Id.*

Petitioner also saw Dr. Michael on February 8, 2010. PX5 at 6. He reported continued, severe and worsening low back and right leg pain as well as nausea and vomiting secondary to the pain. *Id.* Petitioner also reported neck pain, headaches, and arm pain, with minimal activity precipitating severe pain. *Id.* Dr. Michael noted that Petitioner's L2-L3 and L5-S1 disc degeneration with discogenic pain at L2-L3 and L5-S1 were aggravated by his work related injury. *Id.* Additionally, Dr. Michael noted that Petitioner had disc protrusions from C5-C7 with bilateral C6-C7 foraminal stenosis for which he recommended a series of three cervical epidural steroid injections or, alternatively, Petitioner could learn to live with his pain and accept it, which Petitioner felt he could not. *Id.*

On March 1, 2010, Petitioner returned to Dr. Michael. PX5 at 3-4. Dr. Michael noted Petitioner's January 10[3], 2010 forklift incident at work at which time Petitioner reported that he "jerked his low back and neck" which Dr. Michael found resulted in aggravated neck pain, aggravated low back pain, severe headaches, and vomiting. *Id.* Dr. Michael again noted Petitioner's L2-L3 and L5-S1 disc degeneration with discogenic pain at L2-L3 and L5-S1. *Id.* He recommended a posterior lumbar fusion and noted that Petitioner symptoms were even more aggravated, and reiterated his recommendation for three cervical epidural steroid injections to treat Petitioner's C5-C7 disc protrusions. *Id.* Dr. Michael placed Petitioner off work. *Id.*

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[2] The Arbitrator notes that Dr. Michael did not place Petitioner off work prior to this visit.

[3] The Arbitrator notes that the reported date of accident is listed as January 10, 2010 and not January 8, 2010 and no explanation was provided at trial for this discrepancy.

On March 8, 2010, Petitioner returned to Dr. Bender. PX3 at 150-152. He reported left elbow pain at a level of 4/10, low back pain at a level of 8/10 radiating to the right leg, and neck pain at a level of 8-9/10. *Id.* Dr. Bender updated Petitioner's diagnoses to a full body crush injury, lumbago (same by report), left lateral epicondylitis (worse), L2-3 disc bulge, and C5-6 and C6-7 disc bulge. *Id.* She kept Petitioner on light duty work restrictions. *Id.*

On April 9, 2010, Petitioner returned to Dr. Bender. PX3 at 153-154. He reported that he could not feel his legs and fell to the ground three weeks ago at home. *Id.* He also reported only working two or three hours a week, returning more often for medication because it helped with his pain, and tingling in the lower right leg still the same. *Id.* Dr. Bender updated Petitioner's diagnoses to a full body crush injury, lumbago (same), left lateral epicondylitis (worse by report), L2-3 disc bulge, C5-6 and C6-7 disc bulge, and neck pain (worse). *Id.* She kept Petitioner on light duty work restrictions. *Id.*

On May 10, 2010, Petitioner saw Dr. Michael. PX5 at 1-2. Petitioner reported loss of feeling in his legs below the knees, severe headaches, and neck pain. *Id.* Dr. Michael again noted Petitioner's L2-L3 and L5-S1 disc degeneration with discogenic pain at L2-L3 and L5-S1, which he noted were clearly aggravated by his recent injury, and he reiterated his recommendation for three cervical epidural steroid injections to treat Petitioner's C5-C7 disc protrusions. *Id.* Dr. Michael placed Petitioner off work. *Id.*

Petitioner testified that this was his last visit with Dr. Michael because the insurance would not pay for the treatment. He also testified that another attorney recommended MedFinance, a company that does not work with Dr. Michael. Petitioner testified that he did not have the recommended low back fusion at this time because he could not afford it. The Arbitrator takes judicial notice of the Commission's own files and notes that Petitioner had previously filed a motion pursuant to Section 8(a) of the Act on March 8, 2010 and did not file another such motion until July 2, 2012.

Petitioner missed an appointment on May 12, 2010, but followed up with Dr. Bender on May 14, 2010. PX3 at 156-162. Petitioner reported left elbow pain a level of 3/10, burning in the left arm at times, back pain at a level of 8/10 radiating to the right leg at the knee, and neck pain at a level of [illegible]/10. *Id.* Petitioner also reported that he was no longer driving the forklift since April 10, 2010 because it hurt his back. *Id.* Dr. Bender updated Petitioner's diagnoses to a full body crush injury, lumbago (improved), left lateral epicondylitis (improved), bilateral arm and right leg paresthesias, and neck pain (same). *Id.* She kept Petitioner on light duty work restrictions and referred him to one of her partners, Dr. Khanna, for a bilateral upper and lower extremity EMG due to continued complaints of neck and back pain with bilateral upper and lower extremity paresthesias. *Id.*

On June 21, 2010, Petitioner underwent the recommended EMG. PX3 at 163-169. Dr. Khanna found the following: (1) an abnormal left ulnar motor nerve conduction studies with significantly decreased amplitudes of the proximal responses both below and above the elbow which could indicate a forearm conduction block which is a rare finding or a normal anatomical variant of the Martin-Gruber and anastomosis; (2) no evidence of bilateral median neuropathy or right ulnar neuropathy; (3) no evidence of right or left cervical radiculopathy from C5-T1; (4) no evidence of peripheral polyneuropathy; and (5) evidence of a right mid-lumbar posterior rami denervation with no lower limb findings which would indicate lumbosacral radiculopathy. *Id.*

Second Section 12 Examination – Dr. Wehner

Petitioner submitted to a second independent medical evaluation with Dr. Wehner on August 16, 2010. RX12. Petitioner provided additional history and reported to episodes of passing out as well as his second accident at work in January. *Id.* Petitioner reported pain on the top of his head, burning down his left arm, vomiting, that headaches pain at a level of 6/10, and burning in the left hand and on the left side of his face. *Id.* After an examination and review of additional medical records[4], Dr. Wehner diagnosed Petitioner with cervicalgia and low back pain. *Id.* She noted that Petitioner's other symptomatology including abdominal pain, changes in bowel habits, vomiting, passing out and/or seizures, could not be explained based on Petitioner's cervical or low back findings and were not related to his work injury. *Id.* Dr. Wehner stated that she would not recommend any type of epidural injection given Petitioner's history of passing out and vomiting, she noted that Petitioner was diabetic and it was unclear if this was contributing to his other symptomatology, and she opined that he was not a surgical candidate. *Id.* Ultimately, Dr. Wehner opined that Petitioner could work full duty and that his neck and low back conditions were preexisting conditions. *Id.*

Continued Medical Treatment

Petitioner testified that he then went to Dr. Citow, a doctor that works with MedFinance. Petitioner saw Dr. Citow at Lake County Neurosurgery for the first time on September 3, 2010. PX6 at 30-31. Petitioner reported bothersome neck and back pain with pain extending through the right upper extremity toward the thumb and index finger as well as right lower extremity for the lateral foot with numbness, weakness, and paresthesias. *Id.* On examination, Petitioner's neck and back were tender in the paraspinal musculature, his range of motion was limited secondary to pain, his motor strength was 5/5, and sensation was grossly intact. *Id.* Dr. Citow ordered cervical and lumbar MRIs. *Id.*

Petitioner underwent the recommended MRIs which Dr. Citow reviewed and noted as follows: the cervical spine MRI showed spondylosis at C5-7 with foraminal narrowing on the left side at C6-7 and lesser disease at C4-5 and the lumbar spine MRI showed significant spondylosis with moderate foraminal narrowing at L2-3 and some bulging with foraminal narrowing at L5-S1. PX6 at 25. He recommended a follow up visit to discuss further injections and possible decompression surgery. *Id.*

On September 13, 2010, Dr. Citow placed Petitioner off work. PX6 at 24; PX7. Petitioner testified that he has not worked since this date.

October 4, 2010, Dr. Citow's partner, Dr. Alzate, administered facet injections to Petitioner at C5-6 and C6-7. PX6 at 23. Then, on October 15, 2010, Petitioner returned to Dr. Citow reporting continued bothersome neck and back symptoms after three low back injections and one cervical spine injection[5] without any benefit. PX6 at 20-21. On examination, Dr. Citow noted tenderness in the cervical and lumbar paraspinal musculature, limited range of motion secondary to pain, and intact motor strength and sensation. *Id.* He kept Petitioner off work and recommended a C5-7 anterior cervical decompression and stabilization. *Id.*

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[4] Dr. Wehner noted that it was unclear what surgery Dr. Michael recommended and that she did not have his discogram report. *Id.*

[5] It is unclear from the records whether Dr. Citow is referring to Petitioner's prior epidural injections from Dr. Vargas, but there is no evidence that Petitioner underwent additional injections at his office. It is also unclear whether Petitioner underwent one or two cervical injections with his partner, Dr. Alzate.

On November 3, 2010, Dr. Citow ordered preoperative medical clearance testing and kept Petitioner off work. PX6 at 18-19. On December 2, 2010, Petitioner underwent preoperative clearance testing with Dr. Thakkar. PX10.

Petitioner underwent the recommended surgery with Dr. Citow on December 9, 2010. PX6 at 14-17. Pre- and postoperatively, Dr. Citow diagnosed Petitioner with C5-C6 and C6-C7 disc protrusions. *Id.* He performed an anterior cervical discectomy and fusion from C5 through C7 with cornerstone implants, an anterior cervical plate and microdissection, intraoperative fluoroscopy and monitoring with baseline EMGs and continuous EMG monitoring throughout the case as well as bilateral upper and lower extremity motor evoked potentials and somatosensory evoked potentials. *Id.* Petitioner testified that he obtained relief from the surgery.

Petitioner returned to Dr. Citow on December 15, 2010 reporting itchiness, mild discharge, and erythematous rash around the neck and forehead after the bone stimulator implant on December 9, 2010. PX6 at 13. Dr. Citow ordered medications and scheduled a follow-up for December 29, 2010. *Id.* Petitioner returned on that date reporting no radicular arm pain, numbness, weakness, or paresthesias, but some pain between the shoulder blades. PX6 at 12. Dr. Citow kept Petitioner off work and ordered physical therapy and a course of Celebrex. *Id.*

In a narrative letter addressed "to whom it may concern" dated January 6, 2011, Dr. Citow opined that Petitioner's January 10, 2010 injury aggravated Petitioner's July 6, 2009 injury which required him to have the surgery performed on December 9, 2010. PX6 at 11; PX8.

Petitioner returned to Dr. Citow on March 2, 2011. PX6 at 8-9; RX14. He reported neck pain at a level of 5/10 without radicular arm pain and some bothersome back pain and right sided sciatica. *Id.* Dr. Citow released Petitioner back to full duty work without restrictions with regard to the neck, but recommended L2-3 surgery for the back. *Id.* On cross examination, Petitioner testified that he did not recall a full duty release. With regard to the low back, Dr. Citow placed Petitioner on light duty work restrictions with no lifting over 20 pounds, unless his back went out, until his low back surgery. PX9; RX10. Petitioner testified that these restrictions were not accommodated.

Approximately eleven months later, on January 27, 2012, Petitioner returned to Dr. Citow reporting back pain extending through the right leg to the calf and into the left hip related to his work injury. PX6 at 7. Dr. Citow examined Petitioner noting tenderness in the lumbar pure spinal musculature and a limited range of motion secondary to pain with intact motor strength and sensation. *Id.* He ordered a lumbar MRI and noted that he would likely proceed with the L2-3 decompression and stabilization previously recommended. *Id.*

On February 10, 2012, Petitioner underwent the recommended lumbar MRI which the interpreting radiologist noted showed the following: (1) prominent Schmorl's nodes and endplate reactive changes within the lower thoracic spine extending to L3, most prominent at the L2-3 level; (2) diffuse lumbar spondylosis with multilevel annular and neural foraminal disc bulging contributing to neural foraminal stenosis at multiple levels, most severe at L2-3 bilaterally and at L5-S1 on the left side; and (3) grade I retrolisthesis of L2 on L3 and L4 on L5. *Id.*

On March 9, 2012, Petitioner returned to Dr. Citow reporting persistent back pain extending to the right leg to the calf and into the left hip without improvement after medications, therapy, and injections. PX6 at 3-4. Petitioner's physical examination remained unchanged and Dr. Citow noted that Petitioner's straight leg raise test was negative bilaterally. *Id.* Dr. Citow diagnosed Petitioner with lumbar spondylosis and recommended an

L2-3 decompression and stabilization. *Id.* Petitioner testified that this was his last visit to Dr. Citow because he cannot afford additional treatment.

Medical Bills & Temporary Benefits

Petitioner testified that some of his medical bills have been paid, but not all of them. He testified that he has received unpaid bills and gave them to his former attorney, Anthony Esposito.

Petitioner testified that he talked to Joanna at MedFinance and signed documents regarding his medical bills. He testified that he understood that MedFinance would pay for the medical bills and that the only way that he has an obligation to pay MedFinance is if he wins his case.

Petitioner also testified that he has not received any temporary total disability benefits since he was placed off work by Dr. Citow. He testified that he did receive some temporary partial disability benefits, but they eventually stopped and he does not know why.

Petitioner testified that he has not worked since March of 2011. He testified that he has looked for work within a 20 lb. limit, but he did not keep a job log. He testified that he is still looking for work, but he has no list of places where he has looked for work. Petitioner also testified that he applied for unemployment some years ago, but he has not received any unemployment benefits through 2012.

Brad Carder – MedFinance

Brad Carder ("Mr. Carder") is an Illinois licensed attorney and testified that as a representative of MedFinance. He explained that MedFinance purchases medical accounts in personal injury and workers' compensation claims including from CompToday (prescriptions), Lake County Neurosurgery (Dr. Citow), Total Rehab (physical therapy), and Vista Medical Center (the hospital where Petitioner had cervical fusion). Mr. Carder refused to disclose the amount paid by MedFinance to these entities for their accounts with Petitioner. *See also* PX11.

Additional Information

Regarding his current condition, Petitioner testified that he feels bad. He still has headaches, although not so bad as before. He testified that he has lower back popping, which hurts then goes away and that he experiences this every day. Petitioner testified that he takes Aleve, has stomach issues, and there are things that he can no longer do including work because he is up for two days then the third day he passes out due to pain and pressure in the low back.

Petitioner testified that he is going to a free clinic for his low back and that he has not returned to Dr. Michael. He testified that Dr. Citow is his main doctor for the low back and neck. He further testified that he takes prescription medications from the free clinic including cyclobenzaprene for pain, soma, and another unspecified pain killer. He testified that he drove part of the way to court today, but that he can only drive 30-45 minutes before he has to get up.

Petitioner testified that he wishes to undergo the recommended lumbar spine fusion.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at trial as follows:

In support of the Arbitrator's decision relating to Issue (F), whether the Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

The Arbitrator finds that Petitioner's claimed current condition of ill being is not related to his accidents at work on July 6, 2009 or January 8, 2010. In so finding, the Arbitrator finds that Petitioner's testimony is not credible on the whole and is inconsistent with the medical records and the Arbitrator further finds that the opinions of Respondent's Section 12 examiner, Dr. Wehner, are persuasive given the totality of the record.

While Petitioner's first work accident involved a 500-600 pound piece of glass, his claimed injuries as a result of the accident do not directly correlate to the weight of the glass that fell on him as he would have others believe. Petitioner gave testimony about a severe and disabling neck and low back condition of ill being at the time of trial as a result of his work accidents that are not consistent with the objective medical evidence contained in the record about his physical condition or even his reports to various physicians about the work accidents and his claimed ongoing condition.

First, the Arbitrator addresses Petitioner's claimed cervical condition. At trial, Petitioner did not testify about any neck pain occurring immediately after his incident at work. The lack of testimony on this point is notable in light of the medical records which reflect that Petitioner's initial complaints in the emergency room on July 6, 2009 were localized to his chest, abdomen, and left elbow. Petitioner did not report symptoms in the neck or the low back and he was released to work without restrictions.

Two days later, Petitioner went saw Ms. Becker, a certified physician's assistant, reporting right hip, right chest wall, left elbow and inhalation pain with nausea and one episode of vomiting. Petitioner did not report neck pain or low back pain. Notwithstanding, Petitioner's low back was examined along with a general physical examination and he had some low back pain and tenderness to palpation, a bruise on the interior of the right leg, some tenderness to palpation along the right side ribs/abdomen, and some pain and numbness on the left epicondyle. Ms. Becker diagnosed Petitioner with a right chest wall contusion, right abdominal strain, right sacroiliitis, right abdominal contusion, left lateral epicondylitis, right paraspinal muscle strain, and right paraspinal muscle spasm. No cervical condition was diagnosed.

Petitioner continued to follow up with Ms. Becker and then Dr. Bender at Advanced Occupational Medicine Specialists during which time he made no documented complaints of any pain or symptomatology in the neck. Dr. Bender did not examine Petitioner's neck or cervical spine. In fact, Petitioner's neck is not referenced in the medical records until almost three months after the work accident when he first saw Dr. Michael on October 19, 2009 at which time Petitioner provided a different history than that which he reported to emergency room staff or Dr. Bender's office.

Specifically, Petitioner reported loss of consciousness, pain from his head to his right knee, low back pain "much, much worse than associated right leg pain[,]" severe pains with sitting/standing/ walking, particular discomfort with driving and bumpy roads, numbness and tingling in the right second through fourth toes, neck pain and headaches which were bilaterally occipital, and no arm pain, numbness, tingling, or weakness.

Petitioner did not testify about any loss of consciousness at the time of his accident on July 6, 20909 and there is no corroborating reference in contemporaneous medical records about such a condition. Moreover, Petitioner had no arm pain, numbness, tingling or weakness, which is contrary to the reports that he made to Dr. Bender and upon which she relied in rendering diagnoses about Petitioner's radicular pain and any left arm condition.

Shortly after this initial visit to Dr. Michael, Petitioner returned to Dr. Bender on October 27, 2009 and he did not complain of any neck pain. Similarly, Petitioner did not complain of any neck pain to Respondent's Section 12 examiner, Dr. Wehner, on November 16, 2009. While Petitioner argues that Dr. Wehner failed to opine on Petitioner's cervical condition, there is no evidence that Petitioner presented with any complaints related to the cervical spine requiring examination.

Moreover, at no point before or even after Petitioner's second work accident does Dr. Michael causally relate Petitioner's neck condition to either accident at work. To the contrary, Dr. Michael carefully iterates his contention that Petitioner's pre-existing low back condition was aggravated by both work accidents and only then does he add that Petitioner has cervical diagnoses. He does not specifically opine that Petitioner's cervical condition is causally related to either work accident.

Based on all of the foregoing, the Arbitrator finds that Petitioner failed to establish by a preponderance of credible evidence that his claimed current condition of ill being in the neck/cervical spine is causally related to his accident at work on July 6, 2009 or January 8, 2010.

Second, the Arbitrator addresses Petitioner's claimed low back condition. He claims that his current low back condition is causally related to both work accidents and the record is devoid of evidence that Petitioner had any low back symptomatology or treatment before his first accident; however Petitioner's low back treatment, diagnoses, objective test results and testimony about the low back are convoluted at best. Petitioner's treating physicians and Respondent's Section 12 examiner agree, however, that Petitioner had a pre-existing low back condition prior to either accident at work.

The treating medical records reflect that Petitioner's low back was examined and he began complaining of low back pain within days of his work accident. Petitioner was diagnosed with lumbago, right sacroiliitis, and paraspinous muscle spasm as of July 10, 2009. Petitioner, a 46 year old man at the time of his work accidents, underwent a lumbar spine MRI on July 20, 2009 which revealed a disc protrusion at L2-3, end plate degenerative changes, moderate to severe bilateral neural foraminal narrowing and scattered mild other degenerative changes with mild neural foraminal narrowing at L3-4, L4-5, and L5-S1 along with a small focus of susceptibility artifact within the inferior end plate of L2 of uncertain etiology possibly related to a prior surgery. On July 22, 2009, Dr. Bender diagnosed Petitioner with an L2-L3 disc protrusion with foraminal narrowing, L1-S1 facet hypertrophy, and she recommended physical therapy for the low back, which Petitioner eventually underwent.

Petitioner continued to treat with Dr. Bender and she referred him to Dr. Vargas for pain management on August 22, 2009. Dr. Vargas noted that Petitioner's "clinical presentation [was] somewhat perplexing, as *most of his symptoms seem to be right-sided, although he presents a bilateral* neuroforaminal stenosis." *Emphasis* added. These inconsistencies between Petitioner's objective clinical presentation to Dr. Vargas compared to his subjective symptomatology reports are notable in light of the other inconsistencies in this record; that is, Petitioner's testimony at trial about his low back condition and its severity varies from what he reported to physicians during contemporaneous medical treatment and Petitioner's symptomatology and historical reports to physicians during his medical treatment varies among the different physicians treating him or evaluating him for

the low back.

Moreover, the Arbitrator is not persuaded by Dr. Michael's causal connection opinion given the record as a whole. While he vehemently maintained that Petitioner's first, and then second, accident at work aggravated Petitioner's pre-existing low back condition, he did not place Petitioner off work or impose any work restrictions related to the low back until January 11, 2010.

Petitioner testified that he had a second work accident where he was reared ended by a forklift and experienced a burning sensation in his neck and his head became hot. Petitioner did not testify about any low back symptomatology immediately following this second accident and the medical records reflect conflicting historical reports about the accident itself. Interestingly, the medical records also reflect that Petitioner had missed an appointment with Dr. Michael a few days earlier on January 4, 2010 and that he missed an appointment with Dr. Bender on the date of accident, January 8, 2010. Petitioner called Dr. Bender the following day on January 9, 2010 and reported experiencing immediate neck and back pain as a result of the accident, but he declined to come in for an evaluation. Instead, Petitioner scheduled an appointment on January 11, 2010 at which time he reported neck and back pain at a level 10/10, pain radiating from his head to his right foot, and worsened numbness.

Petitioner did not testify about why he missed an appointment with Dr. Bender on January 8, 2010. He did not testify about why he declined to come in for an evaluation the following day on January 9, 2010. There is no evidence about how Petitioner managed the "10/10" maximum level neck and back pain for over three days after the forklift accident without having sought medical attention. Finally, there is no evidence explaining a different and more severe mechanism of injury reported to Dr. Michael on March 1, 2010 where Petitioner reported that he "jerked his low back and neck." Petitioner stopped treating with Dr. Michael after May 10, 2010[6] because he testified that he could not afford it. Petitioner continued to treat with Dr. Bender, however, and she ordered an EMG to address Petitioner's reports of radiating pain into the upper and lower extremities. Petitioner underwent this EMG on June 21, 2010 which showed *no* evidence of bilateral median neuropathy or right ulnar neuropathy, *no* evidence of right or left cervical radiculopathy from C5-T1, *no* evidence of peripheral polyneuropathy, and *no* lower limb findings which would indicate lumbosacral radiculopathy. *Emphasis* added.

In any event, Petitioner testified that he was referred to Dr. Citow, a doctor that works with MedFinance, and he eventually saw him on September 3, 2010. Dr. Citow's records reflect that Petitioner reported bothersome neck and back pain with pain radiating into the right upper and lower extremities for which Dr. Citow ordered updated neck and low back MRIs for an injury at work on January 10, 2010. There is no evidence that Dr. Citow was aware of Petitioner's June 21, 2010 EMG findings, but he nonetheless continued to treat Petitioner for his neck and low back conditions with a focus on the neck first. Notably, Dr. Citow does not opine that Petitioner's neck or low back conditions are work related. It appears that Petitioner relies upon the opinions of Dr. Michael to this effect.

Thus, while it is undisputed between the parties that Petitioner was involved in a forklift accident in January of 2010, the Arbitrator does not find Petitioner to be credible given the inconsistencies in his reported

[6] The Arbitrator takes judicial notice of the Commission's own files. Petitioner filed a motion pursuant to Section 8(a) of the Act two days before his last visit to Dr. Michael on March 8, 2010. This record reflects that Respondent required Petitioner to submit to a second Section 12 examination with Dr. Wehner on August 16, 2010. However, other than Petitioner changing legal representation at some point thereafter and the Commission's files reflecting that a petition for fees was filed by Petitioner's prior counsel on May 22, 2012, no explanation was provided at trial through testimonial or documentary evidence as to why Petitioner did not file a 19(b) or another 8(a) motion until years later on July 2, 2012.

symptomatology to various treating physicians upon which they relied when viewed in light of objective medical evidence and in comparison to Petitioner's reports and clinical presentation to Dr. Wehner. Under these circumstances, the Arbitrator finds the opinion of Respondent's Section 12 examiner, Dr. Wehner, to be persuasive.

Based on all of the foregoing, the Arbitrator finds that Petitioner failed to establish by a preponderance of credible evidence that his claimed current condition of ill being in the low back/lumbar spine is causally related to his accident at work on July 6, 2009 or January 8, 2010.

Finally, while Petitioner did not testify at trial about any continuing symptomatology in the left arm he argues that he has a left arm condition that is causally related to a work accident. The medical records reflect that Petitioner was treated for symptomatology in the left arm; however, no physician has opined that Petitioner's left arm condition is or was causally related to either work accident. Thus, the Arbitrator finds that Petitioner failed to establish by a preponderance of credible evidence that his claimed current condition of ill being in the left arm is causally related to his accident at work on July 6, 2009 or January 8, 2010.

In support of the Arbitrator's decision relating to Issue (J), whether the medical services that were provided to Petitioner were reasonable and necessary, and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

Petitioner sought medical treatment at Advanced Occupational Medicine Specialists and submitted bills for treatment through June 29, 2010. Petitioner sought treatment there at Respondent's behest and Respondent does not dispute its liability for such bills. Thus, the Advanced Occupational Medicine Specialists bills reflected in PX12 are awarded and to be paid pursuant to Sections 8(a) and 8.2 of the Act.

As explained above, Petitioner failed to establish a causal connection between his claimed current condition of ill being in the neck or low back and either work accident. Thus, the bills from MedFinance which were purchased from Dr. Citow for an undisclosed amount, Dr. Vargas, Dr. Michael, Libertyville Imaging, Lake County Anesthesiologists, Dr. Thakkar, and out-of-pocket costs paid to Dr. Citow are denied.

In support of the Arbitrator's decision relating to Issue (L), Petitioner's entitlement to temporary total disability and temporary partial disability benefits, the Arbitrator finds the following:

Petitioner claims entitlement to temporary total disability benefits from July 7, 2009 through December 21, 2009 and from September 13, 2010 through January 25, 2013. AX1-AX2. Respondent concedes Petitioner's entitlement to such benefits from July 7, 2009 through December 21, 2009. *Id.* Notwithstanding, the record reflects that Petitioner was placed on light duty work from July 8, 2009 through December 21, 2009 through treatment at Advanced Occupational Health during which time Petitioner submitted to a Section 12 examination with Dr. Wehner on November 16, 2009. Petitioner returned to work on December 22, 2009. Thus, the Arbitrator awards Petitioner temporary total disability benefits from July 7, 2009 through December 21, 2009.

As explained in detail above, the Arbitrator finds that Petitioner's neck and low back conditions of ill-being are not causally related to work accidents. Thus, Petitioner's claim for additional temporary total disability and temporary partial disability benefits is denied.

In support of the Arbitrator's decision relating to Issues (M), Petitioner's entitlement to prospective medical care, the Arbitrator finds the following:

As Petitioner has failed to establish a causal connection between his claimed current condition of ill being and his work accidents, his claim for prospective medical care is denied.

In support of the Arbitrator's decision relating to Issue (M), whether penalties or fees should be imposed upon Respondent, the Arbitrator finds the following:

Given the facts presented in this case, and after considering the parties' motion and response, the Arbitrator finds that Respondent had a reasonable dispute as to whether Petitioner's condition subsequent to either date of accident was causally related to his injuries at work as alleged and Respondent required Petitioner to submit to two Section 12 examinations. Respondent's conduct was not unreasonable, vexatious and/or in bad faith. Thus, Petitioner's claim for penalties and fees under Sections 19(k), 19(l) or 16 of the Act is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
CHAMPAIGN

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Charles Arnold,
Petitioner,
vs.

NO: 12WC 33664
14IWCC0229

Plastipak Packaging,
Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, temporary total disability, medical expenses both current and prospective and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 18, 2013, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 28 2014
o031914
RWW/jrc
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR

ARNOLD, CHARLES
Employee/Petitioner

Case# **12WC033664**

14IWCC0229

PLASTIPAK PACKAGING
Employer/Respondent

On 7/18/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0465 SCHEELE CORNELIUS & HARRISON
DAVID C HARRISON
7223 S ROUTE 83 PMB 228
WILLOWBROOK, IL 60527

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT MACIOROWSKI
10 S RIVERSIDE PLZ SUITE 2290
CHICAGO, IL 60606

14IWCC0229

STATE OF ILLINOIS)
)SS.
COUNTY OF Champaign)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Charles Arnold
Employee/Petitioner
v.
Plastipak Packaging
Employer/Respondent

Case # 12 WC 33664

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Urbana**, on **May 20, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **September 8, 2012**, Respondent was operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$28,080.00**; the average weekly wage was **$540.00**.

On the date of accident, Petitioner was **60** years of age, **single** with **no** dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services under group.

Respondent shall be given a credit of **$ -0-** for TTD, **$ -0-** for TPD, **$ -0-** for maintenance, and **$377.40** for other benefits for which a credit may be allowed under Section 8(j).

Respondent is entitled to a credit under Section 8(j) for any medical bills paid by their group carrier.

ORDER

Petitioner failed to prove his condition of ill-being in his right foot/ankle was causally related to his accident of September 8, 2012. Petitioner's claim for compensation is denied. No benefits are awarded.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

July 15, 2013
Date

ICArbDec19(b)

JUL 18 2013

Petitioner alleges that he injured his right foot/ankle as a result of an accident on September 8, 2012. The issues in dispute are accident, causal connection, medical expenses, temporary total disability benefits, and prospective medical care. Witnesses testifying at the time of arbitration included Petitioner and Jamie Smith.

Having considered all of the evidence presented, the Arbitrator finds:

Prior to the alleged occurrence on September 8, 2012, Petitioner had undergone both right knee surgery and left knee surgery, the latter having been performed on June 19, 2012, by Dr. Mark Hanson. Petitioner testified that both knee surgeries were brought on by Petitioner twisting his knee and feeling a pop. The records of Dr. Hanson were admitted into evidence as Petitioner's Exhibit No. 1 (PX 1) and they reflect Petitioner's care and treatment through August 29, 2012. (PX 1)

On August 29, 2012 Petitioner presented to Dr. Hanson for a bilateral shoulder evaluation. At that time Dr. Hanson noted right medial knee pain and occasional grinding with a feeling of instability. They discussed scheduling an MRI but Petitioner chose to hold off. (PX 1)

Petitioner works for Respondent as a "technician" and essentially sets up machinery. An Incident Investigation Report was completed on September 8, 2012. According to Part 1 of the Report, which was signed off on by Petitioner, Petitioner injured his right foot on September 8, 2012 when he was walking down the back aisle (west wall near dock C) and tripped over the dock plate stubbing his toe. Greg Wolf was identified as a witness. Petitioner did not seek any treatment at that time. (RX 1) He continued working his regular twelve hour shifts for three days.

Petitioner presented to the office of Dr. Brian L. Hamm on September 12, 2012. Petitioner completed an information sheet as part of the examination. In that form, Petitioner noted he had a work accident on September 10, 2012 when he "tripped on dock plate injured right ankle and leg." (PX 3) In another form completed by Petitioner, Petitioner described his foot problem as "Achilles tendon hurts, tripped ankle swollen, heel, ankle, calf all hurt." (PX 3)

According to Dr. Hamm's office note, Petitioner had been referred to him by Dr. Hanson due to right Achilles pain. Dr. Hamm recorded Petitioner's history of tripping at work a week earlier, experiencing increased pain and swelling, and continuing to work for another three days thereafter. Petitioner presented with "significant pain." Petitioner also reported that he had been standing at work, pivoted to turn around and talk to someone who had spoken to him from behind when he experienced a sharp intense pain but no real "pop or give" that he could appreciate. (PX 3, p. 1) On physical

examination Petitioner had mild edema to his right lower extremity with ecchymosis noted medial and lateral of the Achilles tendon at the level of the watershed area and just distal. Dr. Hamm further noted fusiform edema with significant pain on side to side compression of the fusiform edema within the Achilles tendon on the right but no deficit in the Achilles tendon. Petitioner also had significant pain to palpation of his calf at the myotendinous junction. In light of Petitioner's history of having pivoted followed by the immediate sensation of sharp pain, Dr. Hamm recommended an MRI. He also recommended a cam boot with a thirty pound weight limit. (PX 3, p. 1) Petitioner was given a return to work form indicating he must wear the boot at all times and not push, pull, or lift over thirty pounds. (PX 3)

On September 13, 2012 Greg Wolf provided a written statement regarding the events of September 8, 2012. Mr. Wolf indicated that he had punched in and was walking through line 24 when he noted that Petitioner was screaming loudly into an empty trailer which was docked at the time with the door open. Mr. Wolf could not recall whether he had called out to Petitioner or if Petitioner had kicked a dock door plate before he noted Petitioner screaming. Mr. Wolf walked over to Petitioner and asked if he was okay. Petitioner responded in the negative and continued to yell and shake. Mr. Wolf asked Petitioner if he needed any help and the offer was declined. Later in the day, Mr. Wolf spoke with a co-worker of Petitioner's to see if Petitioner had gone home to "ice his foot" and Mr. Wolf, to his surprise, was advised Petitioner had stayed at work. Petitioner approached Mr. Wolf the next day and apologized for his behavior. (RX 1)

In a letter dated September 20, 2012, Petitioner was advised that Respondent's workers' compensation carrier was denying his claim. (PX 2)

Petitioner underwent a right ankle MRI on September 26, 2012.

Petitioner's Application for Adjustment of Claim was filed with the Commission on September 27, 2012. (AX 2)

Petitioner followed up with Dr. Hamm on September 28, 2012, at which time Petitioner reported ongoing pain. Petitioner's physical examination was similar to that of his earlier September 12, 2012 visit. Dr. Hamm reviewed Petitioner's MRI noting it was consistent with noninsertional Achilles tendinitis but lacking any evidence of a tear. The MRI also showed tendinosis of the peroneus longus and brevis tendons, tenosynovitis of the flexor hallucis longus tendon, a complete tear of the anterior talofibular ligament, interosseous lipoma of the calacaneus, chronic thickening of the central cord of the plantar fascia without rheumatoid changes and edema around the ankle joint. While the MRI was positive

in a number of areas Dr. Hamm noted Petitioner only had clinical evidence of achilles tendinosis. He recommended physical therapy and advised Petitioner to return in three weeks. (PX 3)

On September 28, 2012 Petitioner was given a full duty return to work release effective October 2, 2012. (PX 3)

Petitioner returned to work for Respondent on October 2, 2012. (PX 9)

Petitioner underwent physical therapy beginning October 5, 2012. The initial therapy evaluation notes an onset date of September 8, 2012 when Petitioner tripped on an object at work. (PX 6)

According to Dr. Hamm's medical records, on October 10, 2012, the doctor's office received a call from John Ireland at Respondent's office, requesting clarification on Petitioner's work restrictions. Mr. Ireland was informed that as of September 28, 2012, Petitioner had been released without any restrictions. (PX 3)

Petitioner returned to see Dr. Hamm on October 19, 2012. Petitioner reported improvement in his complaints but ongoing pain while at work, especially on longer days. Petitioner noted that use of the brace, taping, ibuprofen, and stretching exercises helped him get through work. (PX 3; See also PX 6) On physical examination Petitioner still had fusiform edema and pain with side-to-side compression. Petitioner was given an ASO brace and instructed to continue with physical therapy. (PX 3)

Petitioner returned to Dr. Hamm's office on December 4, 2012. Petitioner's diagnosis remained unchanged. Dr. Hamm noted Petitioner had prominence of the Achilles tendon, and pain to palpation in the watershed area. The tendon itself remained intact. Petitioner continued to have plantarflexion of his foot with compression of his calf muscle. In light of the fact Petitioner was only 30% better after 12 weeks of therapy Dr. Hamm recommended ongoing therapy with activity to tolerance or surgical excision of his Achilles tendinosis. Petitioner elected to continue with therapy and wait on surgery. (PX 3)

Petitioner continued with physical therapy through January 30, 2013. As of January 30, 2013 Petitioner was still symptomatic and ongoing therapy was recommended; however, Petitioner reported he might not be able to continue with therapy due to financial constraints. (PX 6)

On February 7, 2013, Dr. Hamm authored a letter to Petitioner's attorney advising him that it was his opinion that Petitioner's achilles tendon injury and/or tendinitis was either caused or, at the very least, significantly aggravated by Petitioner's "reported injury at work one week prior to their September 12, 2012 visit." Petitioner presented with fusiform edema and pain to palpation consistent with his

description of the injury. According to Dr. Hamm Petitioner described a tripping incident at work in which Petitioner was "standing at work [and] pivoted to turn around to talk to someone and felt an intense, sharp pain at the area of his Achilles tendon." Petitioner denied any significant pop or "give" at that time. Dr. Hamm noted that he had last recommended ongoing therapy or surgery. The doctor had not seen Petitioner since December 4, 2012. (PX 5)

At Respondent's request Petitioner was examined by Dr. George Holmes on March 13, 2013. Petitioner reported he was at work on September 8, 2012 when he was "standing and pivoting to talk to [a] coworker. He noted the onset of intense sharp pain without any pop in the right Achilles area." Petitioner told the doctor that physical therapy had been helping. Petitioner was working full duty and using a lace-up brace and taking ibuprofen as needed. Petitioner's complaints included some "achy pain" in the Achilles, especially when going up an incline or using stairs and/or a ladder. Dr. Holmes noted some swelling but nothing "major." Petitioner reported discomfort when walking on a flat surface and with inclines. Heat was helpful in reducing Petitioner's pain complaints. Petitioner was noted to have a history of hypertension and other health issues. Petitioner's examination revealed full range of motion of the ankle, subtalar, and midfoot joints. Petitioner also displayed fusiform thickening in the Achilles tendon and two areas of discomfort along the posterior aspect of the Achilles. Dr. Holmes' diagnosis was Achilles tendinosis; however, he did not feel Petitioner needed any additional care other than a night splint on an ongoing or intermittent basis. Dr. Holmes further recommended that physical therapy "wrap up." Petitioner needed no surgery or work restrictions. Dr. Holmes was of the opinion Petitioner condition "may or may not be related to his work on the dock." He noted that Petitioner did not provide a history of stubbing his toe; rather, he related talking to someone and turning around to talk to someone else – an event that could have happened most anywhere and had nothing "instrinsic to his job." Dr. Holmes did not believe the Achillles tendinosis was "caused" by the motion that Petitioner participated in at that time, but, instead was possibly caused by his underlying history of hypertension and weight. He also noted the MRI demonstrated no evidence of a tear, edema, or collateral damage attributable to an acute injury. In sum, Dr. Holmes opined Petitioner's condition was more likely than not due to the fact it was Petitioner's "time to become symptomatic from his Achilles tendinosis and tendinopathy." (RX 2)

At arbitration Petitioner testified that he twisted his right ankle at the age of sixteen while playing baseball and sliding into home base. He wore a cast for about six weeks and, thereafter, had no further problems. Petitioner further acknowledged bilateral knee problems. Petitioner explained that in 2005 he felt a pop in his right knee while turning it at home. He had surgery on his knee and it remained a little

painful thereafter. Petitioner also injured his left knee in May of 2012 when it popped while he was turning in his kitchen. Petitioner was off work for two weeks and was released in August of 2012.

Petitioner also testified that when he was last examined by Dr. Hanson on August 29, 2012, he was experiencing some right ankle pain, he mentioned the complaints to Dr. Hanson and Dr. Hanson recommended he go see Dr. Hamm, another doctor in the same clinic. Petitioner further testified that an appointment was made for him to see Dr. Hamm on October 12, 2012. Petitioner's attorney asked Petitioner what, if anything, he noticed about his right leg when seen by Dr. Hanson in August of 2012. Petitioner testified he was having some ankle pain. Petitioner's attorney then responded, "Right ankle pain?" to which Petitioner responded, "Right ankle pain, yes."

Petitioner testified that at the time of his occurrence, he was employed as a Technician for Respondent. Petitioner testified that it was his job to set up machinery and it required him to be on his feet and lift up to 15 pounds. Petitioner testified that on September 8, 2012, he was walking into work to punch in and Greg Wolf, a fellow employee, was walking in the opposite direction when Greg called out his name. Petitioner testified that he caught his toe on a plate and felt pain going up his calf. Petitioner further testified that he would talk to Wolf on occasion and they talked about baseball or "Illinois." Petitioner testified that the conversation that he had with Wolf that day was not related to work.

Petitioner testified that he was screaming and Greg Wolf asked him if he was okay and he said "no." Petitioner further testified that he reported to his work station and worked 12 hours on Saturday, 12 hours on Sunday and 12 hours on Monday. He testified that he sought no medical care on any of those days.

Petitioner testified that he informed his foreman about the incident at the "after the morning meeting" and he completed an accident report two days later. Petitioner testified that the pain he was experiencing did not go away over the weekend.

Petitioner testified that he went to Dr. Hamm on the 12th and the doctor ordered an x-ray, MRI, boot, and took him off work. Petitioner further testified that he took the note to his employer and that he gave a recorded statement two days later when an adjuster called.

Petitioner testified that he continued treating with Dr. Hamm who ordered physical therapy and released him to return to work on October 2, 2012. Petitioner further explained that he was given a lace-up brace to work but only wore it at home due to safety issues. Petitioner testified he stopped going to physical therapy in January of 2013 because the bill was getting too high.

Petitioner acknowledged seeing Dr. Hamm on September 12, 2012. When confronted with the history of "he states that while he was standing at work, he pivoted to turn around and talk to someone

who had spoken to him from behind and had a sharp intense pain but without real history of pop or give way that he could be appreciated" Petitioner denied same. After the denial, he was asked by Respondent's counsel about the history he gave to Dr. George Holmes (RX 2). The history to Dr. Holmes was "he reports standing and pivoting to talk to a co-worker. He noted the onset of intense sharp pain without any pop in the right Achilles area." Petitioner denied giving that history to Dr. Holmes. He was then asked how both doctors could have the same incorrect history. Petitioner's response was that "they must have been thinking about his knee injuries which occurred that way."

Petitioner testified he would like to receive further treatment for his injury. He further testified that he has changed jobs at work due to ongoing soreness but that he feels like his knee has healed. Petitioner currently works nights sitting in the guard shack. to being taken off work on September 12, 2012 and being released to return to work on October 2, 2012. He testified to the conservative care and physical therapy he was provided to include wearing a boot at home, and then a closed shoe at work for safety reasons. Petitioner testified that he would have difficulties with stairs, but his condition was getting better. He testified that he stopped physical therapy because he could not afford the co-pays. He testified that he last saw Dr. Hamm in December of 2012. Petitioner acknowledged he is 5'5" tall and weighs between 290 and 295 lbs.

Petitioner admitted to going to the IME with Dr. Holmes. He admitted that he was suffering from hypertension. He testified that he was taking medication for his hypertension and was not taking any medication for his Achilles tendon injury. Petitioner testified that Jamey Smith filled out the incident report based upon information Petitioner provided to him. Petitioner further testified that he told Jamey Smith that his ankle hurt at the time of the incident.

Jamey Smith testified on behalf of Respondent. Mr. Smith is Petitioner's supervisor. Mr. Smith testified that Petitioner reported an incident to him on September 8, 2012 in which Petitioner stubbed his toe. Mr. Smith asked Petitioner if he wanted medical care and Petitioner denied it. Mr. Smith did not recall Petitioner ever mentioning any ankle pain. On cross-examination Mr. Smith acknowledged that Petitioner complained of toe and foot pain over the course of the next three days but he was able to work and it wasn't until September 10th that he requested an accident report be filled out.

The Arbitrator concludes:

Petitioner testified that he was experiencing right ankle pain prior to September 8, 2012. Petitioner testified that when seen by Dr. Hanson in August of 2012 he mentioned right ankle pain complaints to

the doctor and it was recommended that he go and see Dr. Hamm, another doctor in the clinic. An appointment was scheduled for October 12, 2012 before Petitioner injured himself on September 8, 2012. Petitioner testified that on September 8, 2012 he tripped over a dock plate. The accident on September 8, 2012 involved Petitioner's right toe, not his ankle. When Petitioner was examined by Dr. Hamm on the 12th Petitioner gave a history of tripping at work and experiencing an increase in pain. Petitioner didn't say his pain began with the incident at work; rather, something happened that made the pain greater than it had been. Petitioner had right ankle pain before anything happened on September 8, 2012.

The Arbitrator further notes the history contained in Dr. Hamm's initial visit of September 12, 2012, which clearly suggests that Petitioner had two incidents one occurred when Petitioner tripped over the dock plate; the other involved pivoting when Mr. Wolfe called out to him. Which of these incidents occurred exactly when is uncertain although it appears the tripping at work occurred approximately one week before Dr. Hamm's visit and he worked another three days thereafter. Petitioner did not indicate when the pivoting incident occurred. The pivoting accident at work would not be compensable. If Petitioner was responding to Mr. Wolf's calling out to him and pivoted, Petitioner's accident did not arise out of his employment as there is was no increased risk of injury stemming from Petitioner's employment. Petitioner was going in to clock in and was exchanging pleasantries with Mr. Wolf regarding subjects having nothing to do with work.

The Arbitrator concludes that on September 8, 2012 Petitioner sustained an accident arising out of and in the course of his employment when he tripped over the dock plate. Petitioner testified as such. Petitioner's accident report (RX 1) described the incident as a trip over a dock plate. Mr. Wolf's statement does not shed a great deal of light as he could not recall if he had called out to Petitioner or if Petitioner had kicked a dock door.

The Arbitrator further concludes that Petitioner failed to prove that his current condition of ill-being in his right ankle or foot is causally related to the September 8, 2012 accident. Petitioner has the burden of proof regarding causation. Petitioner failed to meet that burden of proof as Dr. Hamm's opinion is based upon an inaccurate history regarding Petitioner's injury as Petitioner failed to explain to the doctor how he was experiencing right ankle pain prior to September 8, 2012, and the appointment in September was requested for the prior complaints and not as a result of the September 8, 2012 accident. Tripping and pivoting are two distinct actions and nowhere does Petitioner give a history of both occurring at the same time. Petitioner's failure to give any doctor a complete and accurate history of his ankle and foot complaints undermines any causal connection determination. The Arbitrator is also not convinced by a preponderance of the evidence that Petitioner's pain in his Achilles tendon began on September 8, 2012.

There is also a discrepancy between Dr. Hamm's medical records and his causation opinion (PX 5). In Dr. Hamm's office note of September 12, 2012, he clearly associates the pivoting action with the Achilles tendon injury and not the tripping episode. (PX 3, p. 1) His opinion letter to Petitioner's attorney suggests differently but not persuasively. (PX 5) Furthermore, Drs. Hamm and Holmes were both given the same exact history of a pivoting accident and not a tripping accident. Petitioner's testimony that the doctors must have been confusing his knee injury histories with his ankle complaints was not convincing given the complete circumstances of the case.

Petitioner's claim for compensation is denied and no benefits are awarded.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF ADAMS)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Russell Grady,
Petitioner,
vs.

NO: 11WC 15158, 11WC15164
11WC 15178, 11WC 15353

State of Illinois/Jacksonville Developmental Center,
Respondent,

14IWCC0230

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of nature and extent, accident, causation, temporary total disability, medical, wage calculations, "motion to strike application per accident,"and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 7, 2013, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

DATED: MAR 3 1 2014
o032514
CJD/jrc
049

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GRADY, RUSSELL
Employee/Petitioner

Case# **11WC015158**

11WC015164
11WC015178
11WC015353

SOI/JACKSONVILLE DEVELOPMENTAL CENTER
Employer/Respondent

14IWCC0230

On 5/7/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

2934 JOHN V BOSHARDY & ASSOC PC
1610 S 6TH ST
SPRINGFIELD, IL 62703

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PARKWAY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

3291 ASSISTANT ATTORNEY GENERAL
DIANA E WISE
500 S SECOND ST
SPRINGFIELD, IL 62706

0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST
13TH FLOOR
CHICAGO, IL 60601-3227

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305/14

MAY 7 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

14IWCC0230

STATE OF ILLINOIS)
)
COUNTY OF ADAMS)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Russell Grady
Employee/Petitioner

v.

State of Illinois/Jacksonville Developmental Center
Employer/Respondent

Case # 11 WC 15158

11 WC 15164, 11 WC 15178
11 WC 15353

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Nancy Lindsay, Arbitrator of the Commission, in the city of Quincy, on March 6, 2013. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

D. ☒ What was the date of the accident?

E. ☒ Was timely notice of the accident given to Respondent?

F. ☒ Is Petitioner's present condition of ill-being causally related to the injury?

G. ☒ What were Petitioner's earnings?

H. ☐ What was Petitioner's age at the time of the accident?

I. ☐ What was Petitioner's marital status at the time of the accident?

J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD

L. ☒ What is the nature and extent of the injury?

M. ☐ Should penalties or fees be imposed upon Respondent?

N. ☐ Is Respondent due any credit?

O. ☐ Other _____

FINDINGS

On **March 16, 2011** , Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned $ **56,873.04** ; the average weekly wage was $ **1,093.71** .

On the date of accident, Petitioner was **45** years of age, ***single*** with **0** dependent children.

Petitioner *has* received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit for $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $ **729.14**/week for **6 & 5/7** weeks, commencing **March 24, 2011** through **Aprill 11, 2011 and then again from April 14, 2011 through May 12, 2011** , as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $ **656.22**/week for **66.625** weeks, because the injuries sustained caused **17.5% loss of use of the right hand and 15% loss of use of the left hand** as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner compensation that has accrued from **March 16, 2011** through **March 6, 2013** , and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay $ **26,102.73** for medical services, as provided in Section 8(a) of the Act. Respondent is entitled to credit for any actual related medical expenses paid by any group 8(j) health provider and Respondent is to hold Petitioner harmless for any claims for reimbursement from said group health insurance provider. Respondent shall pay any unpaid, related medical expenses according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Nancy Lindsay
Signature of arbitrator

May 3, 2013
Date

ICArbDec p. 2

MAY - 7 2013

Russell Grady vs. State of Illinois - Jacksonville Developmental Center
IWCC No. 11 WC 15158

Petitioner has four claims pending against Respondent, all of which allege repetitive trauma to Petitioner's upper extremities with different accident/manifestation dates. At the time of arbitration, all four claims were consolidated with the parties agreeing that one decision would be issued. The disputed issues are accident; causal connection; notice[1]; earnings; medical expenses; temporary total disability; and nature and extent.

ATTACHMENT C

In support of the Arbitrator's findings on the issue of **(C) Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent? (D) What was the date of accident, and (E) was timely notice of the accident given to Respondent,** the Arbitrator finds the following facts:

The findings of fact stated in other parts of this decision are adopted and incorporated herein by reference.

On March 16, 2011, Petitioner was employed by Respondent at the Jacksonville Developmental Center. Jacksonville Developmental Center is a residential facility for mentally and physically disabled adults.

Petitioner first began working at Jacksonville Developmental Center in May of 1988. Petitioner began his employment as a Mental Health Tech trainee. Petitioner became a Mental Health Tech I in 1989. Petitioner became a Mental Health Tech II in 1990. In 2000, Petitioner was promoted to a Mental Health Tech III.

Petitioner cared for approximately 30 to 32 residents. There were two wings of sixteen residents each and the Petitioner moved from one wing to another during his workday as needed.

When Petitioner was a Mental Health Tech II there were only two workers on each wing. The Mental Health Tech III position was created when the Petitioner began working as one in 2000. The position did not exist before then. Petitioner testified that when working as a Mental Health Tech II his work activities were very similar to those he performed as a Mental Health Tech III with the only difference being that when Petitioner became a Mental Health Tech III the amount of activity with his hands increased.

Petitioner described his work activities as a Mental Health Tech III. Petitioner worked forty hours a week and would be required to work a mandated overtime shift once or twice a week, which he described as an extra eight hour shift. Petitioner could refuse a mandated overtime shift only twice a year.

[1] Respondent stipulated to notice in 11 WC 015353

Petitioner arrived in the morning and had to get the residents out of bed. Petitioner stated that most of the residents were soiled so Petitioner would have to clean them. About fifteen or sixteen of the residents could not walk. If the residents were not able to stand, Petitioner would use his hands and arms to roll them on the side by placing his hands on the residents' back and buttocks, holding the residents with one hand, taking the wet sheets out, and cleaning them with his other hand. Petitioner rolled the residents back and forth with his hands until they were clean. Petitioner dried the beds by wiping them down and then dressed the residents.

Dressing the residents required Petitioner to hold them on their side with his hand and pull on the residents' socks, underwear, pants, and shirt with the other hand. Petitioner testified that dressing the residents was very difficult because they did not want to cooperate. The residents would kick, move, squirm, and Petitioner would really have to hold them with his hands tightly and hang onto the clothes hard to slide on the clothes. Petitioner dressed at least 20 residents a day. Dressing the residents took about an hour.

After the residents were dressed, Petitioner fed the 40% of the residents who were unable to feed themselves. Petitioner scooped up the food with a spoon using his hand and poured the drinks in a cup. Sometimes the residents did not like the food and would spit it back, so Petitioner kept on trying to feed them.

After Petitioner was done feeding the residents, he would take them to the bathroom and assist them in sitting on a toilet. Petitioner testified that he brought approximately ten residents to the toilet and the rest of them would have to be laid on the bed to have their diapers changed. The residents were required to be toileted every two hours due to all the fluids that they would be given.

In toileting, Petitioner used his hands to unbuckle the resident's pants, pull them down, sit them on the toilet and wait a while. If the residents were unable to sit on a toilet, Petitioner had to lay the resident on the bed, pull down the resident's pants and underwear, pull their adult diaper off, and change them. If the residents were not able to stand up, he would have to lay them on the bed and roll them with his arms and hands. The residents were not cooperative.

Eighty percent of the residents were in wheelchairs, so it would be necessary to lift them out of the wheelchair and lay them on the bed. Some of the residents weighed 100 pounds, others weighed over 300 pounds. Petitioner had to lift them, position them to remove the diapers off, and then dress them again.

Some of the residents who were in wheelchairs would not stay in the facility all day. Approximately twenty five of the thirty two residents would go to a workshop. In order to take them to workshop Petitioner lifted them underneath the legs and behind their back, and set them in wheelchairs. The heavier residents required two people to lift them, with one at the feet, and one on the back.

When the buses showed up, Petitioner would push the residents outside, down a very steep ramp, and load them on the bus. Petitioner testified that because the ramp was so steep he would need to grip and hold onto the wheelchair to prevent picking up too much speed.

Some of the residents could not ride the bus, so he would push them all the way to the workshop, which was approximately 200 yards.

If the residents did not go to workshop, Petitioner would do hand to hand activities. In these activities Petitioner would grab the resident's hand with his own hand and rub an item, such as a piece of sandpaper, or silk, and show the resident the texture of the item. Most of the residents would not cooperate because they did not like to be touched. Petitioner explained that he would have to forcefully grip the resident's hand, hang onto it, and pull them to the object being touched.

Petitioner also described that he would need to reposition the residents so they did not develop bedsores. The residents had to be moved every hour. Any resident in a wheelchair would need to be moved from the wheelchair to the bed and from the bed to a recliner.

Petitioner cleaned the furniture. Petitioner cleaned the mattresses every day. Petitioner used a spray bottle of bleach and cleaned the furniture with a towel with his hands. Petitioner removed the sheets, sprayed the mattresses with a bottle of bleach and wiped it down with his hands.

Petitioner also remade the beds. There was a bed pad, a fitted sheet, a flat sheet, a blanket, a bed spread, and pillow cases. Petitioner would make the majority of the beds as the group leaders stayed with the residents. The urine would soak through, so Petitioner would have to mop up the floors as well.

Petitioner also completed paperwork everyday. Petitioner stated that he had to do the paperwork longhand. He would have a face-check sheet that he would have to mark every half an hour with a pen. Every day Petitioner needed to write a progress note regarding what the residents did, note their behavior, and if anything happened. If a resident left the campus, a note needed to written on where they went and what they did. If there was an injury Petitioner had to write about an hour's worth of paperwork. In addition to the face-check sheets, Petitioner would also complete a walkthrough paper. Petitioner testified that every month they would have new paperwork that he would need to complete.

Residents became combative every day. When the residents became combative, Petitioner needed to use quite a bit of exertion to restrain or control them as they were very strong. Petitioner testified that he had to hold them down using his arms, shoulders, and hands.

Petitioner stated that eighty to ninety percent of his day involved gripping or forceful gripping with his hands.

Petitioner's testimony regarding his work activities was un-rebutted.

Petitioner noticed that he developed occasional numbness approximately two years before he mentioned the problem to his doctor. Petitioner noticed that his condition worsened over the two years preceding a visit he had with his primary care physician, Dr. John Peterson of Jacksonville Family Practice on January 28, 2011. (P.X.4) Petitioner saw his doctor on January 28, 2011 for a recheck of his hypertension medication when he noted that he had arm and hand

pain. Petitioner's blood pressure on January 28, 2011 was 130 over 90. (P.X. 4) Petitioner stated that he did not discuss his work activity with him and a diagnosis was not provided to him by his doctor. (P.X.4) Dr. Peterson made a provisional diagnosis of carpal tunnel and referred the Petitioner to Dr. Fortin for an NCS. (P.X.4) Petitioner was not restricted from working.

Petitioner was seen by Dr. Claude Fortin on February 23, 2011 for an EMG/NCV study. (P.X.11, Dep. Ex. 2) Dr. Fortin noted he had a two year history of bilateral hand numbness which had been increasingly problematic at night for the past year. Petitioner testified that he did not discuss his work activities with Dr. Fortin and the records confirm this. Dr. Fortin diagnosed the Petitioner with bilateral severe carpal tunnel syndrome. (P.X. 11, Dep. Ex. 2) Petitioner stated that Dr. Fortin told him he had carpal tunnel syndrome.

Dr. Peterson referred the Petitioner to Dr. Darr Leutz of the Springfield Clinic for treatment of his bilateral carpal tunnel syndrome. (P.X.5, Dep. Ex. 2) Petitioner was seen by Dr. Leutz on March 16, 2011. Petitioner testified that Dr. Leutz discussed with him the cause of carpal tunnel and this was when Petitioner was first informed that his work activities could have caused his bilateral carpal tunnel syndrome.

Petitioner notified his supervisor of his diagnosis of bilateral carpal tunnel syndrome on March 17, 2011 and Petitioner was provided with a workers' compensation injury packet which he completed on March 18, 2011. Respondent stipulated that it received notice of the Petitioner's claim of bilateral carpal tunnel on March 18, 2011.

The Arbitrator notes Petitioner's credible testimony and finds Petitioner's bilateral carpal tunnel syndrome manifested itself on March 16, 2011, as that is the date on which Petitioner became aware that he had the condition and that it might be related to his employment. There is no evidence indicating that Petitioner had this knowledge until he discussed his work activity with Dr. Leutz on March 16, 2011. The Employer's Form 45 dated March 18, 2011 states that Petitioner was experiencing discomfort in both wrists due to repetitive dressing and undressing of clients. (PX. 2) Petitioner filed four applications for adjustment of claim alleging four separate manifestation dates, with March 16, 2011 being one. The case number for accident date March 16, 2011 is 11 WC015158.

The Arbitrator concludes that the accident date for purposes of this claim is March 16, 2011 and since Respondent acknowledged receiving notice on March 18, 2011, notice to Respondent has also been established. The Arbitrator makes no findings or conclusions with respect to the other claims filed.

Russell Grady vs. State of Illinois - Jacksonville Developmental Center
IWCC No. 11 WC 15158

ATTACHMENT F

In support of the Arbitrator's findings on the issue of **(F) Is the Petitioner's present condition of ill-being causally related to the injury?,** the Arbitrator finds the following facts:

The findings of fact stated in other parts of this decision are adopted and incorporated by reference here.

Dr. Darr Leutz testified in this matter on the issue of causal relationship, as did Respondent's IME physician, Dr. James Williams.

Dr. Leutz diagnosed the Petitioner with bilateral carpal tunnel syndrome. (P.X. 5, Dep. Ex. 2) Dr. Leutz performed bilateral carpal tunnel releases to treat the condition of ill being. (P.X. 5, Dep. Ex. 2)

Dr. Leutz performs about two to three carpal tunnel releases per week, or 90 to 150 cases per year. (P.X.5, p. 19) Dr. Leutz stated that about half are caused by work injuries. (P.X.5, p. 19)

Dr. Leutz stated that people with carpal tunnel syndrome will commonly have symptoms at night. (P.X.5 p. 8) Dr. Leutz felt that the Petitioner did not have any systemic conditions which might predispose the Petitioner to develop carpal tunnel syndrome besides being overweight. (P.X.5, p. 8)

Dr. Leutz testified that he is a little familiar with the duties of a Mental Health Tech III and it was his usual practice to ask patients like Petitioner about their work activities. (P.X.5, pp. 15-16, 20-21) Dr. Leutz did not note Petitioner's work activities in his initial record but noted it was his practice to discuss work activities with his patient. (P.X.5 pp. 20, 23)

Dr. Leutz was provided a hypothetical description of the Petitioner's work activities which, although less detailed than the Petitioner's testimony regarding his specific work activities, provided a fair and accurate summary of the Petitioner's work activities and the use of his hands as a Mental Health Tech III. (P.X.5, pp. 16-17) Dr. Leutz stated that the activities described would either be causative or an aggravation of his carpal tunnel syndromes. (P.X.5, p. 18)

Dr. Leutz felt that the Petitioner's work activities were repetitive and strenuous. (P.X.5, pp. 18-22) Dr. Leutz stated that it was his opinion that Petitioner's activities were repetitive and strenuous because of the activities of "donning and doffing of clothes", moving patients, lifting residents from side to side to clean, grasping sheets, and other care-giving activities involving pulling, grasping, pushing, and lifting. (P.X.5, p. 22)

Dr. Leutz stated that he did not know how long the Petitioner would have to perform this activity to be considered repetitive. (P.X.5, p. 22) Dr. Leutz noted that the activities described were strenuous to the hands in that they required Petitioner to lift and reposition patients such as other care giver type situations such as nurses which have the same type of phenomena happen. (P.X.5, p. 18)

Dr. Leutz testified that there is no test to determine how much repetitious activity a person has to experience before developing carpal tunnel syndrome and the amount of repetitious activity required would depend on that person's predispositions, genetics, and the amount of time a person is performing the tasks. (P.X.5, pp. 27-28) Dr. Leutz stated that idiopathic meant that there was no explanation for the development of carpal tunnel in an individual. (P.X.5, p. 29) Dr. Leutz was of the opinion, however, that because he felt the Petitioner's work activities did contribute to his carpal tunnel syndrome, the Petitioner's carpal tunnel syndrome was not idiopathic. (P.X.5, p. 29)

Dr. Leutz opined that having high blood pressure or hypertension was not a cause of carpal tunnel syndrome. (P.X.5, pp. 24-25)

Respondent sent Petitioner to Dr. James Williams for an independent medical evaluation on May 9, 2012 for the purpose of an independent medical evaluation. (R.X. 4. p. 5) Dr. Williams reviewed a "Job Demands Report" or job description prepared by Christina Austin. (R.X. 4, pp. 9-10) Dr. Williams stated it was his opinion, "based on the job description", that Petitioner's work activities did not cause or aggravate his carpal tunnel syndrome because he did not think that the job activities required any vibration or sustained, repetitive, forceful gripping. (R.X.4, pp. 14-15) Petitioner's counsel made a timely objection to a discussion of the "Job Demands Report" based on hearsay and foundation. (R.X. 4, p. 9-10) Petitioner's counsel reiterated the objection at arbitration. Respondent failed to offer the testimony of Christina Austin, the person who created the "Job Demands Report" to establish a foundation for its admissibility or for cross examination. Dr. Williams testified that the causation opinions he made in his IME report were based on the job description. (R.X. 4, p. 12) The Arbitrator sustains the Petitioner's objection and strikes the "Jobs Demand Report" and any causation opinions offered by Dr. Williams based thereon.

Petitioner did not provide Dr. Williams with any more information about his work activities other than what was in the "Job Demands Report". (R.X. 4, p. 23) Accordingly, Dr. Williams had no other admissible facts on which to base a causation opinion.

Dr. Williams stated that it was his opinion that the job duties of a Mental Health Technician III were very similar to a CNA. (R.X. 4, pp. 13-14) Respondent offered no evidence regarding the activities of a CNA or how the same might be similar to the work of a Mental Health Technician III.

Dr. Williams was asked whether there were any treatises which he knew which would support his opinon. (R.X. 4, p. 15) Petitioner's counsel moved to strike the question and answer since Respondent did not disclose any such treatises to Petitioner's counsel within 48 hours of Dr. Williams' deposition. (R.X. 4, p. 15) Petitioner offered as Williams' Deposition Exhibit 3 Petitioner's counsel's letter to Respondent's counsel dated October 10, 2012, along with a facsimile confirmation report receipt of same, demanding production of, inter alia, any medical treatises on which Dr. Williams might rely. (R.X. 4, Deposition Exhibit 3) The Arbitrator sustains Petitioner's counsel's objection and Dr. Williams' opinions based on any such medical treatises are stricken.

On cross-examination, Dr. Williams admitted that he had been retained by Respondent to perform independent medical evaluations on Respondent's employees since February 2011.

(R.X. 4, p. 17) Dr. Williams admitted performing three such exams per week, which had recently increased in that since April or May of 2012 Dr. Williams had been performing as many as 3 to 4 were for Respondent. (R.X. 4, pp. 17-18) Dr. Williams admitted that he received $2,000.00 per examination every week before November of 2011, but thereafter his fee increased to $2,500.00 per examination. (R.X. 4, p. 18)

Dr. Williams did not have the Mental Health Technician II job description and had no information about those work activities. (R.X. 4, p. 21)

Dr. Williams agreed that carpal tunnel syndrome was a cumulative disorder syndrome. (R.X. 4, p. 21)

Dr. Williams admitted that he had no information that the Petitioner might be required to forcefully restrain a combative adult disabled person. (R.X. 4, p. 23) Dr. Williams admitted that he had no description of the activities Petitioner would perform in repositioning a combative or redirecting a combative adult mentally handicapped individual. (R.X. 4, pp. 23-24) Dr. Williams admitted that dressing a severely mentally handicapped adult might require restraint but did not know the type. (R.X. 4, p. 24)

Dr. Williams admitted that there are systemic factors which might predispose a median neuropathy. (R.X. 4, p. 24) Dr. Williams agreed that carpal tunnel syndrome is very often occupationally related. (R.X. 4, p. 25) Dr. Williams classified hypertension as a risk factor for carpal tunnel syndrome. (R.X. 4, p. 27) Dr. Williams noted that the Petitioner's blood pressure was only slightly elevated at 140 over 97 on the day of his exam. (R.X. 4, p. 39) Dr. Williams agreed that not all people with hypertension will develop carpal tunnel syndrome. (R.X. 4, p. 41) Dr. Williams also admitted that there are no studies which isolate hypertension as a cause of carpal tunnel syndrome. (R.X. 4 pp. 41-42)

Dr. Williams stated that Petitioner had two predisposing risk factors in being mildly obese and hypertensive. (R.X. 4, pp. 27-28) Dr. Williams agreed that there were no specific number of repetitions that a person must experience to develop carpal tunnel syndrome. (R.X. 4, p. 28) Dr. Williams admitted that since there was no baseline number of repetitions that a person must experience to bring about the symptoms of carpal tunnel syndrome in any given individual, the amount of repetitious activity a person must be exposed to varied from person to person based upon a combination of genetic predisposition, systemic risk factors, and occupational risk factors. (R.X. 4, p. 33) Dr. Williams further admitted that there was no way to determine with any scientific certainty what proportional contribution systemic factors provide in a given patient. (R.X., 4, p. 34)

Dr. Williams acknowledged that varying work activities does not necessarily mean that the worker is not using their hands. (R.X. 4, pp. 43-44) Dr. Williams also acknowledged that the Petitioner worked "a lot" of overtime and the Respondent did not inform him that Jacksonville Developmental Center had mandated overtime hours. (R.X. 4, p. 47) Dr. Williams acknowledged that the number of hours a person works is important in determining occupational risk. (R.X. 4, pp. 47-8)

The Arbitrator notes that both Dr. Leutz and Dr. Williams testified that occupational risk factors exist which might cause, aggravate, or contribute to the development of carpal tunnel syndrome, often in conjunction with predisposing health issues and genetic factors.

The Arbitrator finds that Dr. Williams did not have any facts regarding, or admissible description of, the Petitioner's work activities on which to base his causation opinions and, therefore, his opinions against a finding of a causal relationship cannot be given any weight.

The Arbitrator notes Petitioner's credible testimony regarding his work activities and Dr. Leutz' testimony of a causal relationship between Petitioner's work activities and the bilateral carpal tunnel syndrome Petitioner developed. The Arbitrator concludes that Petitioner's bilateral carpal tunnel syndrome was causally related to his work activities and accident of March 16, 2011.

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ATTACHMENT G

In support of the Arbitrator's findings on the issue of **(G) What were Petitioner's earnings?**, the Arbitrator finds the following facts:

The findings of fact stated in other parts of this decision are adopted and incorporated by reference here.

Petitioner submitted his earnings records from the pay period ending April 1, 2010 through pay period ending March 14, 2011. In all but one pay period, that ending December 1, 2011, Petitioner received overtime earnings. Petitioner testified that overtime was mandated due to understaffing and he could only refuse mandated overtime twice a year.

Petitioner's gross earnings, including overtime for the period, above was $56,873.04 yielding an average weekly wage of $1,093.71. (P.X. 3)

The Arbitrator concludes that Petitioner's average weekly wage for purposes of this claim is $1,093.71.

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ATTACHMENT J

In support of the Arbitrator's findings on the issue of **(J) Were the medical services that were provided to the petitioner reasonable and necessary?**, the Arbitrator finds the following facts:

The findings of fact stated in other parts of this decision are adopted and incorporated by reference here.

Petitioner submitted his related medical expenses as Exhibit 10. Having resolved the issue of accident and causal relationship in Petitioner's favor, the Arbitrator concludes the medical expenses submitted were reasonable and necessary and orders Respondent to pay the same as follows:

Jacksonville Family Practice, 1/28/11	$ 124.00
Springfield Clinic, 2/23/11-4/20/11	$ 9,230.00
Passavant Area Hospital, 3/16/11	$ 240.96
Passavant Area Hospital, 3/24/11	$ 6,165.53
Passavant Area Hospital, 4/14/11	$ 6,910.37
Passavant Area Hospital, 4/28/11-5/16/11	$ 2,326.87
Anesthesia Care Associates, 3/24/11	$ 510.00
Anesthesia Care Associates, 4/14/11	$ 595.00
Total:	**$26,102.73**

As stipulated by the parties, Respondent is entitled to credit for any actual related medical expenses paid by any group 8(j) health provider and Respondent is to hold Petitioner harmless for any claims for reimbursement from said group health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent is to pay unpaid balances with regard to said medical expenses directly to the providers. Respondent shall pay any unpaid, related medical expenses according to the Fee Schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner.

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ATTACHMENT K

In support of the Arbitrator's findings on the issue of **(K) What amount of compensation is due for Temporary Total Disability?**, the Arbitrator finds the following facts:

The findings of fact stated in other parts of this decision are adopted and incorporated by reference here.

Dr. Leutz removed Petitioner from work following his left carpal tunnel release on March 24, 2011. (P.X.5, p. 11) Petitioner was released to return to work without restrictions on April 11, 2011 and then removed again from work following his right carpal tunnel surgery on April 14, 2011. (P.X. 5, Dep. Ex. 2) Dr. Leutz released Petitioner to return to work on May 12, 2011 without restrictions.

The Arbitrator concludes Petitioner was temporarily and totally disabled from March 24, 2011 through April 11, 2011 and then again from April 14, 2011 through May 12, 2011, a period of 6 and 5/7 weeks.

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ATTACHMENT L

In support of the Arbitrator's findings on the issue of **(L). What is the nature and extent of the injury?** the Arbitrator finds the following facts:

The findings of fact stated in other parts of this decision are adopted and incorporated by reference here.

Petitioner underwent bilateral carpal tunnel releases by Dr. Darr Leutz with the left carpal tunnel release being performed on March 24, 2011 and the right carpal tunnel release being performed on April 14, 2011. (P.X.7 & 8) Dr. Leutz noted Petitioner's median nerve had an hourglass appearance. (P.X.7 & 8)

Petitioner now works for the Respondent for a different agency as Jacksonville Developmental Center closed. Petitioner now works in the mail room for Department of Human Services. Petitioner notes that his right hand grip is not all the way there and he drops envelopes. Petitioner estimates that he has lost 20% to 30% of his grip strength on his right hand and 5% to 10% loss on his left hand. He notices his right hand feels swollen but it is not swollen, almost like a fullness feeling to it.

Dr. Williams performed grip strength testing over a year after Petitioner's surgeries and Dr. Williams noted that the Petitioner's grip strength on the right, his dominant hand, was decreased when compared to his left hand. (R.X. 4, pp. 44-46, Dep. Ex. 4) Dr. Williams testified that the dominant hand should be 10 to 15% stronger on the dominant hand than the non-dominant hand.(R.X. 4, p. 46) The test was done approximately one year postoperatively and showed a "bell shaped curve" showing maximum voluntary effort. (R.X. 4, pp. 44-5)

The Arbitrator notes that the testing demonstrates Petitioner has a measurable loss of grip strength of approximately 20% on the right. Normative values were not available to compare Petitioner's original grip strengths. The Arbitrator concludes the injuries sustained caused 17.5% loss of use of Petitioner's right, dominant hand, and 15% loss of use of Petitioner's left hand.

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